Assessing the Social and Mental Health Services Provided to Middle-Eastern Newcomers in the Resettlement Process in the National Capital Region

Thesis

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Abstract

This is a qualitative case study based on a literature review, an analysis of the websites of two social service organizations, and interviews with 16 social service providers (counselors, physicians, community leaders) who work with newcomers from conflict affected countries in the Middle East. This study explores the social and mental health services provided to newcomers in the National Capital Region, and identifies the internal and external obstacles associated with the resettlement process and reception of mental health treatment options. Social environments, gender roles, pre-migration experiences and cultural implications play a role in the resettlement process and the ability to live in the host country. The mental health services offered acknowledge the cultural differences between the immigrant population and the host country's population; there is evidence that mental health services in Canada are incorporating the cultural differences into the therapy methods. While this has begun, there are still many difficulties associated to stigma, language barriers, misunderstandings of social norms and institutions, and structural issues linked to that fact that the federal government funds many of these mental health services.

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I would also like to thank my family for their support and, ultimately, their experiences that led me to research this topic. The personal struggles felt by my family, as well as other newcomer families, have always remained a source of inspiration and a foundation of strength in life. The resilience, positivity and sacrifice demonstrated by these families are encouraging factors to any immigrants striving for a better life. Their struggles and hardships of migrating to a new country and building up a life for their family is truly inspiring and has forever ingrained a level of ambition and strength to surpass all obstacles in life. They are truly an inspiration and were the starting ground for this research.

Chapter 1: Introduction

As of 2013, it has been reported that Canada's immigrants share accounted for 20.7% of the population (MPI, 2013). Among those, 24% of permanent residents derived from Africa and the Middle East (CIC, 2014). Canada is one of the main destinations in the world to migrate, and support for immigration policies remains strong despite any economic or demographic shifts and slowdowns (Ferrer et al., 2014).

The country's immigration policy has shifted over the past 50 years, and is currently functioning on a "points system" with a selection grid that is directed at hiring skilled immigrants (CIC, 2015). The shift in increasingly admitting immigrants as part of the economic class, and fewer in the family reunification and refugee classes (Ferrer et al., 2014) impacts the Canadian labour market, immigration programs and the overall demography of the country. Regardless of this shift to economic classes, newcomers in Canada have experienced decreasing economic outcomes when compared to their Canadian-born counterparts (Ferrer et al., 2014), which may be attributed to educational accreditation issues and linguistic barriers. Canada aims to mitigate these issues by employing a series of tests, including language tests with minimum requirements necessary for each program (Ferrer et al., 2014). These changes have shown a positive impact in the individuals admitted to Canada as well as their economic prospects and contributions to the country (Ferrer et al., 2014)

However, many newcomers are refugees and others who have been displaced due to oppression, conflict or war in their countries of origin. The newcomers include migrants who have left either prosperous and comfortable standards of living, or those who have witnessed

the circumstances of war and have not experienced high standards of living. The present state of the Middle-Eastern region is unstable and many newcomers arrive in Canada due to wars, population displacement, political instability, religious persecution (real or imagined), economic deprivation, and the existence of attractive conditions in Canada (Hayani, 2014). While the pre-migration experience will affect a newcomer's experience in Canada, adjusting to a new country, system, society, and geographical destination is a difficult and daunting process for anyone.

Newcomers undergo linguistic and psychological adjustments, as well as adapting to how their host society functions (Hayani, 2014). While newcomers from the Middle East as well as other countries are subjected to the pressures of adopting Canadian norms and values, the country itself must be flexible to adjust and change to accommodate its growing, pluralistic population.

The adjustments that newcomers and Canadians undergo are not limited to physical, economic and linguistic adaptations – there are many psychological effects that must be tended to and that are derived from past experiences of having lived in unstable political environments. Mental health disorders may be due to previous traumas and/or the constant life changes; if left untreated, may develop into physical illnesses as well.

Having recognized these long-lasting impacts, the City of Ottawa in the National Capital Region (NCR), along with the Government of Canada (GoC), aim to ensure that programs, and social and mental health services are made available to newcomers. The fact that government departments fund these services can provide great benefits to newcomers, but can also cause newcomers to be reluctant to disclose personal information to the counselors

employed by these organizations. Mitigating the effects of their pre-migration will allow for a better transitional process and a healthier Canadian workforce and overall process.

There are a variety of services offered to cater to different needs and groups. Social service organizations in the NCR and elsewhere, funded by the federal government, provide newcomers with the tools and techniques to settle into society, including settlement orientations, education, and counseling services.

All newcomers undergo a three-month waiting period before their provincial health insurance takes effect, with the exception of Convention Refugees and those in need of protection (OHIP, 2012). This becomes problematic when newcomers arrive to Canada and must overcome their mental health disorders while adjusting to the transitional process of making this important life-change. The mental health services offered in the NCR come in a variety of formats: psychiatric care, psychological services as well as community-based rehabilitation (CBR) services that incorporate collaborative techniques with the community (Berge et al., 2009).

CBR methods recognize the importance of incorporating the community as the main component in the process and base their interventions and treatment methods based in this setting (Berge et al., 2009). The community in question is defined as a group of individuals and complex relationships that are participating or involved in a process (Drolet & Mohamoud, 2010). There is a level of flexibility of the program offered and level of inclusiveness of all the members, who simultaneously develop a sense of co-ownership in the process (Berge et al., 2009). The members include family, community leaders, mental health professionals and other individuals that are ‘stakeholders’ in the treatment process (Berge et al., 2009).

These programs are offered in a variety of formats through providers – whether delivered by clinical institutions or by social service organizations in the community. Clinical psychiatric services and primary health care providers play an important role in the healthcare system because patients will often solicit their help and care first (Grazier, 2008). While the literature discusses the difference in effectiveness between clinical individual psychiatric or psychological therapy and community-based rehabilitation treatment options with regards to North America and various cultures, there is a gap in the literature with respect to Middle-Eastern newcomers who have lived in war-torn countries.

The obstacles related to integration into society as well as the psychological impacts of the transition on the migrants necessitate care and services from the host country. My research employed a constructivist perspective by studying a multitude of actors that offer their own perceptions and interpretations of the same conflict, services and treatment options available (Guba & Lincoln, 1994). This is integral to the research because the different members involved in these services, including those providing and receiving the care, will have varying interpretations on their effectiveness and appropriateness to the culture in question. By seeking recognition and input of the different actors involved, there will be a different reconstruction and understanding of the potential need for social and mental care services as the knowledge will constantly be changing.

Along with these obstacles are the difficulties faced with cultural identity and the internal struggles of adopting certain traits, values and social norms from their culture of origin, their host country's culture and any others that they are exposed to.

Research Question

There is a need to better understand the obstacles and difficulties faced by newcomers from the Middle East who arrive in Canada and who utilize the social and health care services to aid in the resettlement process. My research focused on the following questions:

- Have the organizations in the National Capital Region (NCR) and other metropolitan cities in Canada provided services to this population?
- How do the counsellors interpret the effectiveness of the services offered?
- What have the newcomers communicated to the counsellors regarding their perception of the information, standards and services provided to them and what internal and external obstacles were present to help or hinder their resettlement process?
- How does Canada's mental health care system perceive, react to and treat the mental health states in these Middle-Eastern newcomers and how they have adapted their therapies to accommodate this population?

Chapter 2: Literature Review

This thesis examined the existing research and the gaps in the literature as well as how my research can contribute to the existing knowledge. I reviewed information pertaining to newcomers in Canada from governmental and other sources. As per the Government of Canada, a newcomer is defined as an individual from outside Canada who has recently established residential ties in the country (CRA, 2015). This

encompasses protected people (within the Immigration and Refugee Protection Act), people who have applied for and/or received permanent resident status, as well as those who have received "approval-in-principle" from Citizenship and Immigration Canada (CIC)to stay in Canada. These people are also eligible for and require a social insurance number (CRA, 2015).

2.1 Canadian Immigration Programs

Canada has established several programs for immigrants entering the country. These programs cater to specific needs and include different eligibility criteria, as listed below. These apply to my research as my study examines all types of newcomers that have entered the county in any one of the following programs (CIC, 2015):

Program	**Description**
Federal Skilled Workers	This program, managed by a new Express Entry portal, is designed for applicants with skilled professional work experience.
Canadian Experience Class	This program is designed for people with in-Canada skilled professional work experience and applies to all provinces and territories except Quebec
Federal Skilled Trades Program	This program is designed for applicants who have at least two years of full-time work experience in a skilled trade and meet the requirements outlined in the National Occupational Classification (NOC)
Quebec-selected skilled workers	Individuals must apply and be accepted by the Quebec government before applying to Citizenship and Immigration Canada (CIC) for permanent residence

Provincial nominees	These applications are designed to allow provinces and territories nominate immigrants who want to settle there and require then to directly apply to that province/territory in question
Start-up visa	Designed for applicants who wish to prove their business ventures and be supported by a designated organization
Self-employed people	For applicants who would like to become self-employed in the agriculture, sports or arts sectors.
Caregivers	Individuals can apply through three subprograms, including Caring for Children Pathway to provide childcare in a home; Caring for People with High Medical Needs pathway for those caring for the elderly or with chronic disease; and Live-in Caregiver program for those already working in Canada to achieve permanent residence status.

Then there are newcomers who utilize the Canadian sponsorship programs:

- Family sponsorship: as citizens or permanent residents, individuals may sponsor their spouses, dependent children, parents and grandparents as well as other eligible relatives to become permanent residents in Canada.
- Sponsoring refugees: individuals or groups can sponsor refugees and provide financial and emotional support during their sponsorship including food, clothing and housing.

The immigrants who arrive in Canada using these programs are not limited to those coming from war zones.

A large focus of this study is on individuals who have witnessed or have been victims of violence at some point in their lives. Regardless of their immigration status, they have

sought help from the community leaders and organizations interviewed. This encompasses refugees, permanent residents, and individuals on work visas, as well as any other status that have arrived to Canada using various immigration channels. For the purposes of this thesis, none of these individuals were excluded because they all maintain valuable experiences and insight that contributes to the research. These individuals will hereinafter be referred to as newcomers for the remainder of the thesis.

2.2 Middle-Eastern Newcomers

Since 1948, a series of conflicts and repressive regimes have created an outflow of migrants from parts of the Middle East. Many have come to Canada, either as refugees or under some other immigration category. Given the circumstances that led to their departure, many of these newcomers have faced traumas and may benefit from mental health services in Canada (Sabatinelli, Pace-Shankin, Riccardo & Shahin, 2009). In 2010, approximately 280,000 newcomers came to Canada (Statistics Canada, 2013). Between 2006 and 2011, approximately 40,420 newcomers settled in the National Capital Region (2011 National Household Survey, 2013). By helping these individuals get over their mental health issues, they can progress with their daily routine and can integrate themselves in society.

Like many other newcomer populations, many Middle Eastern newcomers have undergone difficult experiences in their country of origin and this often manifests in symptoms of mental health disorders[1]; including anxiety, depression and post-traumatic stress disorder. The host country bears the responsibility for establishing services for these individuals in order to treat their mental health disorders, allowing them both to achieve a

[1] Disorder: Following the American Psychiatric Association diagnostic manual, I will use the term disorder throughout my research as a general term. http://www.dsm5.org/Pages/Default.aspx

better state of mental health, and to integrate themselves as contributing members of society. In addition to the mental health disorders and obstacles that may be faced by newcomers, the issues associated to acculturation and establishment in a new country are vast. There are services offered in the NCR that reflect the need of newcomers including workshops on citizenship tests, the housing market, women's empowerment and counseling and referral services. Social service organizations need to take into account their cultural differences and the language barriers that may be faced in providing care to such people. My research examined CBR services and traditional individualized clinical and psychiatric care in treating Middle-Eastern newcomers with mental health disorders. The cultural implications examined consist of different customs, beliefs, and values. The structural organizations in the health care system are also observed in both a clinical psychiatric context an in community-based rehabilitation services aimed at treating mental health illnesses in Middle-Eastern newcomers from conflict zones.

Additional factors that lead to mental health symptoms experienced by newcomers include: exposure to war, state-sponsored violence and oppression, internment in refugee camps, displacement, loss and separation of family members, low socioeconomic status and unemployment (Savin et al., 2005). Such factors place a heavy burden on the individual, especially when exposed to the difficulties of adapting to a new society, which present new challenges on a daily basis.

2.3 Cultural Identity

Canada is known for its multicultural identity. With the help of technology and globalization, Canadians are increasingly adopting different aspects from various cultures and are forming different identities (Adler, 1977) through the elimination of barriers and

increases in cross-cultural communication and interactions. The traditional geographic, linguistic and cultural barriers that existed are dissipating and cultural identity is being formed based on social, political, economic and educational interactions (Adler, 1977). The notion of 'placelessness' is becoming increasingly common, and cultural preservation and cultural differences become more difficult to achieve (McIntosh et al., 2002).

This identity is not founded in the sense of belonging to a specific group, but rather, founded on the fact that the individual is neither included nor excluded from their culture, but can find their identity within the traditional and mainstream cultures instead (Adler, 1977).

Cultural identity can be defined in various ways. In its collective meaning, it is identified as the collection of appropriate and inappropriate behaviors and the sharing of values, beliefs and customs (Adler, 1977). In its individual meaning, cultural identity refers to an individual's relation to their culture and if it becomes a part of their being. In either case, this concept relates to an individual's integration of values, beliefs and attitudes of a specific group – this is usually identified with a name or label (of a country, religion, gender, etc.) which is recognized and understood by others (i.e. an American Buddhist) (Adler, 1977). An individual will also internalize norms, behaviors, and rules to live by and the interaction with other members of society or the same culture are based on these values (Adler, 1977). The interconnectedness of the values, beliefs and norms in a culture function in relation to the collective and individual sense of identity (Adler, 1977).

A person who identifies themselves as being multicultural is open to different values and traits from cultures presented to them and this can become bewildering. If the individual is unable to personally sort through these traits, they may feel pressured to behave and

believe what others are telling and this overwhelming feeling can render a person confused as to which culture to live by (Adler, 1977). Because an individual is able to grasp traits from various cultures, they can be identified by several roles that may conflict with one another, resulting in disjointed personalities that follow what their society dictates (Adler, 1977).

Newcomers often experience culture shock, which differs from the regular obstacles of the resettlement process – it is the misreading of social cues and interactions. In these situations, a newcomer may undergo assimilation or integration, which are distinguished by the retention of the cultural traits versus the adoption of the mainstream culture (Adler, 1977). However, if an individual identifies with their original cultural group, they are more likely to favor assimilation whereas those who prefer the host society's cultural traits will undergo assimilation (Adler, 1977). Ancestral cultural traits succumb to the dominant norms and lifestyles in the host society (McDonough, 1998).

2.4 Clinical and Psychiatric Health Care Services

By drawing upon Palestine to serve as an example of a Middle-Eastern country in conflict, Horton (2009) notes the importance of the health professionals' roles in alleviating the stressors caused by living in a war-torn country and the population's need for structures that offers the necessary health care services. He goes on to state the necessity of a fully functioning health care system that serves to allow health care professionals to treat mental health disorders and to serve as a model for the global health care community in realizing the importance of this treatment and its obligation to society (Horton, 2009). Grazier (2008) notes that individuals who do seek help for mental health illnesses will often solicit care services from their primary health provider. This is further echoed by Rochefort and Portz's

(2009) argument that, in North America, mental health care services are offered in the form of outpatient and aftercare options, but the majority of services lie in clinical institutions. Savin et al. (2005) place great importance on the necessity of health delivery from health care professionals and recommend having the practitioners assess the mental health states of newcomers at the onset of their arrival, during their initial public health examination. This leads to early treatment, which allows early healing, and consequently contributes to the overall health status of the individual, allowing them to contribute not only to their families, but their society and community as well.

While the necessity of rapid treatment is widely understood, Wilson (2001) describes the limitations of general practitioners (GPs) and their ability to assess and treat the mental health needs of the individuals. He notes that various ethno-cultural groups remain dissatisfied with the services provided to them by their GPs, which is further reflected in the frequency with which they consult their health professionals. Newcomers also feel that their GPs and the local health services are unable to assist with the special problems that they are facing (Wilson, 2001), specifically referring to their past experiences of living in a conflict zone.

Highlighting one of the factors based on the organizational structure of the healthcare system relates to the difficulty associated with seeking professional health services. As expressed by the counsellors, newcomers awaiting their status changes from the government and may be fearful of bringing attention to their mental health situations because they believe it may lead to them being sent back to their country of origin. Healthcare systems across North America need to ensure that the needs of these minority groups are taken into account, including their cultural background as well as ensuring that these services are

planned and provided to individuals in partnership with their local communities (Wilson, 2001).

Ruwanpura et al. (2006) discovered that health care providers have had success when following a combination of therapeutic treatment programs, which have combined both cultural and religious coping strategies. Such strategies are carried out simultaneously and harmoniously, and are perceived as appropriate solutions to treating mental health distresses in individuals with varying cultural backgrounds. This combination of therapeutic techniques maintains the importance of the individuals' cultural and spiritual beliefs as well as incorporating Western medical therapeutic techniques. An additional factor relating to the organizational structure of Ontario health care systems, as experienced in the NCR, relate to the financial implications, unfamiliarity of such institutional practices, and varying cultural beliefs that can discourage individuals from seeking professional services (Rochefort & Portz, 2009). This is part of the culture shock and difficulties of entering a new and unfamiliar country.

2.5 Community-Based Rehabilitation Services

Community-based rehabilitation services are an accompanying form of treating certain disorders, and incorporate a variety of techniques and methods, which rely highly on community interaction, family resilience and group therapy. The different techniques encompass methods such as art, dance, and music therapy, offering the individual a chance to express her/himself and convalesce in a manner that better corresponds to their culture and that they feel more comfortable partaking in. Cultural differences play a role in treatment because certain cultures interpret psychological symptoms such as anxiety, fatigue and

depression as mental disorders and may seek relief through family support which is deemed one of the strongest coping strategies identified (Ruwanpura et al., 2006).

Along with involvement of community circles and social networks, creative arts therapies are commonly used, incorporating art, music and dance. Koch (2009) depicts how this method includes non-verbal approaches that draw upon cultural familiarities and present themselves as non-threatening approaches to healing. This method further encourages discussion and validation of the newcomers' experiences and traumatic past events. Jones (2007) demonstrates how music therapy can be used as an effective method by being incorporated into individuals' lives on a daily basis, which encourages them to become more involved in the community and results in a greater state of well-being. Hosin (2001) notes that not all individuals require the same level of rehabilitation which can be attributed to their resilience to difficult events. The difference in resilience highlights the advantages of the various techniques used in community-based rehabilitation services, as they can be tailored to the individuals' specific needs. Consequently, there is no universal treatment for such diverse reactions to the traumatic experiences faced by these newcomers. The events that are experienced collectively should be treated collectively and not on an individual basis. (Giacaman, Shannon, Saab, Arya & Boyce, 2006; Hosin, 2001).

Resembling the reactions to traumatic events, resilience is also measured differently for each individual and is another component of community-based rehabilitation. Walsh (2002) defines resilience as one's ability to withstand disruptive challenges in life, and is traditionally perceived as an individualistic coping mechanism. Resilience is also defined as the patterns established to recover from and adapt to dramatic changes, and utilizing the services and community support to do so (Ungar, 2011). Community-based healthcare

began in Canada in the 1950s; however, due to the lack of financing and proper mental health programs, there was very little standardization of care across the country (Rochefort & Portz, 2009). There is a possibility that incorporating complementary therapeutic methods may benefit the immigrants over the long term, which can lead to long-tern health benefits for the newcomers and the health care system.

By maintaining the constructivist perspective throughout my research, I examined how the front-line workers and the newcomers see the process of adaptation and resettling to a new country and the services offered to assist in this process. Arriving in a new country will test the individuals and their families' resilience in many different facets, including community integration, employment and financial challenges, societal norms and language barriers (Boyd, 2006), studies have taken into account the importance of family resilience, which is the ability of facing challenges together as a family unit and strengthening the family bonds (Walsh, 2003). This is especially helpful in the case of younger children, who may be less resilient than older children (Punamaki, Qouta, Miller & El-Sarraj, 2011) and may need greater support.

2.6 Literature Gap

There remains a gap in the literature when examining community based rehabilitation services in treating Middle-Eastern newcomers suffering from mental health disorders in Canada. The case of Middle-Eastern newcomers suffering from mental health disorders and the Ontario health care structures and social services created to treat these individuals is not widely studied. My research aims to contribute to filling this gap because it created the linkages missing between newcomers from the Middle-East and their perceptions of the

health care treatment options offered in the National Capital Region. In Canada, the health care system continuously undergoes changes to better serve the population and my research will help identify any further changes that need to be addressed based on the newcomers' experiences and their health and social service needs.

Chapter 3: Methodology

This is a qualitative case study based on a literature review, an analysis of the websites of two social service organizations, and interviews with 16 social service providers (counselors, physicians, community leaders) who work with newcomers from conflict-affected countries in the Middle East. Due to the nature of my research it is important to examine the perspective of all actors involved and this is reflected in the method of data collection through in-depth interviews with counselors, psychologists, psychiatrists and community leaders. This method has ensured a level of validity and reliability because it maintained the integrity of the information expressed by the newcomers, as perceived by the counsellors, since their perceptions, feelings and coping strategies were directly communicated through the social service providers (Taylor & Bodgan, 1998). I analyzed the interview transcripts for trends, themes and concepts that were both researched in the literature review as well as those that arose throughout the interviews, because I am seeking to understand these individuals' experiences from their perspectives. The literature reviewed on the general perceptions of Middle-Eastern newcomers and mental health disorders, revealed that there is little or no literature expressing how the communities and health care systems found in Canada have used complementary treatment methods and techniques.

By employing open-ended semi-structured interviews, the participants were not given strict guidelines or boundaries as to the topic in question. The topics mentioned in the interview guide included (but were not limited to): the services offered by the organization or professionals, different types of therapies used and their success rates, the participants' impressions and satisfaction with the services provided, and any structural improvements that can be made in this field. The interviewee was allowed to digress into various accompanying and sometimes unrelated topics, further enriching the research (Patton, 2002). Structured interviews would not have been an ideal format for this research because the interviewees need the flexibility to express their feelings and the feelings of the newcomers surrounding their very emotional experiences due to the regimented structure that is maintained by the interviewer (Patton, 2002), further emphasizing the constructivist nature of this research. Many individuals interpreted and perceived the same situation in very different ways, and these common and divergent themes will be mentioned throughout my paper. The ideal interview type for my research design is semi-structured interviews, as they allow for greater flexibility in dialogue and exploring a series of topics, while maintaining direction through a set of questions and themes to be covered (Berg, 2009).

My research sought to explore the mental health and social services offered to newcomers in the resettlement process, as well as those who are experiencing mental health disorders due to pre- or post-migration experiences. By employing semi-structured interviews, I was able to identify the trends, through a content analysis of the transcriptions, faced by many of the newcomers who are seeking the services, and the counselors were be able to share certain techniques or treatment options that are more effective to certain symptoms as well as some themes shared by all the individuals.

While semi-structured interviews are a good form of data collection for my research, there are limitations involved with the execution of the interviews. There are difficulties associated with replicating interviews, and each one differed, especially with guiding the interviewees to discuss certain subjects (Gray et al., 2007). An interviewer should remain open during the interview, and that they should not seek any specific information but rather let the dialogue unfold naturally. This is a difficult aspect to maintain during interviews, because biases play a large role in perception and have the potential to negatively influence in process (Caplow, 1956). Body language also plays an important factor and must be taken into consideration when conducting an interview, because it may also unintentionally impose certain expectations to the interviewee and influence their responses (Frankfort-Nachmias & Nachmias, 2001), along with the way the questions are phrased and posed. In order to alleviate these concerns, I maintained a neutral and objective outlook throughout the interview process and ensured that I was aware of my body language and verbal communication with the interviewees.

There are always risks with respect to the truthfulness of the information provided in interviews (Marshal & Rossman, 1999). This is likely not a factor in my research due to the guarantee of anonymity given to the interviewees, as well as the fact that the interviews were deemed low-risk, which further encouraged the interviewees to speak truthfully. As per the organizations' policies, all information related to the clients is kept confidential, and this was upheld throughout the interview process. My research design is qualitative in nature, encompassing techniques that are used for complex issues that cannot be answered by a simple 'yes or no' answer. The data collected in the form of words were analyzed using descriptions and narratives and the recurring concepts became expressed themes that are

important for data. Another guarantee of the truthfulness of the interview data was gained through triangulation: data collected in one interview could be compared with other interview data and with data from other, non-interview sources such as the organisation's website[2], official government data, and the researcher's own experience as a member of this community.

3.1 Study Population and Selection of Participants

A mixed group of health and social service professionals was used because they are all involved in a person's treatment cycle as well as the settlement process. For this reason, other professionals were interviewed for the purpose of this thesis including researchers, medical physicians and religious community leaders. As agreed upon, the identities of all the interviewees have been protected throughout this thesis. The individuals will be referred to using pseudonyms and references towards their positions and professions, but any identifiers will be excluded.

Finding counselors to interview was a difficult task because few organizations offer newcomer services, as well as the fact that the information they are privileged to is highly sensitive. These difficulties also applied to finding clinical practitioners, psychiatrists and psychologists who treat this target population and are able to provide insight on the developing trends while under their care. I employed a snowball sampling method in finding interviewees, having these counselors nominate further subjects participants or colleagues; this technique reinforces a sense of trust in the research and the interview itself. The search for participants for the interviews was comprised of an extensive online search for psychiatric and psychological medical professionals in the National Capital Area.

[2] The organizations' websites cannot be explicitly cited throughout the research due to the promise of confidentiality.

Government and healthcare websites were consulted, which provided lists of said professionals. Because the individuals contacted were either unable/uninterested in participating, or did not have enough experience with the Middle-Eastern population, I was forced to expand my search to include other individuals and leaders in the community that were able to contribute to the research. Please refer to the table below for a summary table of the professionals that participated in the interviews:

Pseudonym	**Organization / Profession**	**Background Experience**
Albert	Religious Leader	Experience with refugees in a metropolitan Canadian city
Ronald	Religious Leader	Experience with refugees and family group counseling
Amal	Talbet Organization	Senior Clinical Counselor (licensed psychiatrist in another country)
Ester	Talbet Organization	Community Service Worker and led women's group sessions
Molly	Talbet Organization	Community Service Worker and led women's group sessions
Mark	Talbet Organization	Clinical counselor
Patty	Prescott Organization	Resettlement Worker for new immigrants
Nancy	Prescott Organization	Employment Counselor and ran work-related group sessions
Rachel	Prescott Organization	Newcomer Information Officer
Sam	Prescott Organization	Credentials Assessment Worker
Martin	Physician	Physician specializing in refugee healthcare
Matt	Physician	Physician at the Ottawa General Hospital
Amanda	Physician (Toronto)	Curriculum Leader and a Registered Counselor
John	Independent Service Provider	Occupational Health Physician
Sarah	Independent Service Provider	Researching refugee children's educational and psychosocial needs
Madden	Independent Service Provider	Executive of clinical youth treatment services
Organization A		Talbet Organization
Organization B		Prescott Organization

Interviews were conducted with eight counselors from two organizations in Ottawa that provide services such as supportive counseling and crisis intervention and aid in integration into Canadian society. While these interviews were not conducted with the newcomers themselves, the counselors were able to recount their experiences, concerns, obstacles and illness as they were expressed in the counseling sessions. This does limit the participants to directly communicate information for the purposes of the thesis. However, the counselors have the advantage of meeting several members of the population of relevance and can speak to broader trends/issues.

As mentioned on their websites and program descriptions, the organizations offer the following services: assistance with immigration, housing, employment and financial needs, translation services, crisis intervention and conflict resolution. One of the organizations provides services in Ottawa to over 25,000 newcomers yearly. Both offer therapy sessions in a variety of formats including individual sessions, group therapy and workshops and family group sessions.

Additionally, the fact that the counselors employed at these organizations speak several languages eliminates the language barrier in the client-counselor relationship, which facilitates an easier exchange of information in the sessions. The freedom to express one's self in their mother tongue becomes appealing to individuals, along with the fact that the counselors represent a variety of cultures, which may lend the impression to the patients that they can express certain cultural notions and be understood. Finally, the organizations offer referral services to the community, as needed. This cultural understanding and integration also reinforces the similarities between the Canada and the Middle-East and does not separate them into two distinct entities.

The researcher interviewed include a worker (Sarah[3]) based in Calgary that worked with children resettlement from Uganda and South Sudan, and John, who worked with Aboriginal youth experiencing social and psychological integration issues. They were selected for the study to offer valuable insight on children's development during transitional phases experienced by migration as well as phases of difficulty with social integration.

The religious community leaders in Ottawa, Albert and Ronald, were interviewed to examine the religious and cultural component associated with the resettlement process and also provide an outlet for individuals to discuss their issues or concerns with a trusted advisor. Religion plays a large role in providing a sense of security for individuals, from being able to practice one's beliefs to being able to access a network of like-minded individuals that share similar values. Albert and Ronald both represent two prominent religious communities found in Ottawa, with members that are predominantly from Middle-Eastern descent. Albert's religious community encompasses over 400 families. He has worked with immigration services and assisting families throughout his career. Ronald's community offers a variety of programs to provide social services, counseling and guidance to families that involve enhancing their spiritual beliefs while becoming contributing members of the Canadian society.

Finally, four physicians were interviewed for their clinical experiences with immigrant populations that are undergoing the resettlement process and that may be experiencing forms of mental health illnesses. The criteria selection for the physicians included those who have worked with newcomers who have experienced living in a war-torn country or conflict zones. Their contribution to the study is based on their impressions and

[3] Pseudonyms have been used to ensure anonymity of the interviewees as well as the organizations and religious institutions involved in this study.

observations of the patients themselves and of any trends that they note among these similar groups of patients. These practitioners are located in both Ottawa and Toronto. Two physicians in particular, Amanda and Martin, work in Toronto with refugee groups. Amanda is a psychologist whose patient population is composed of mostly Iranian women that are experiencing mental health issues, resettlement obstacles and difficulties establishing cultural identities in Canada. Martin, in turn, has worked with new refugee families, has advocated for refugee policies and aids in the post-migration process. Along with the physicians in Ottawa, they were selected because they could provide perspective on the shortfalls and successes of the Ontario health care system in treating newcomers to Ontario/Canada.

The literature suggests that non-Western immigrants carry certain influences with them that affect the way they respond to conventional Western forms of psychological treatment (Hosper et al, 2007). It is essential to incorporate these cultural customs and beliefs. In order to do so, health care professionals must first determine what these influencing factors are, how they influence the patient, and understand how the problem is perceived in the culture to be able to create a program with an achievable goal for the patient (Cohen, 1981). By incorporating professionals who are influential in a person's community, the treatment may involve specialists including doctors, priests, teachers, parents, psychotherapists, police, military, spiritual leaders, among others (Cohon, 1981). It would be more effective to incorporate and identify these influencing factors in a patient's life and integrate them to the treatment method instead of expecting the patients to "alter their beliefs about illness and treatment to fit an existing system in the host culture (Cohon, 1981). Given

these facts, a variety of counselors, therapists, physicians and community leaders were interviewed.

There are reasons justifying the choice of counselors and not the newcomers themselves. The counselors are trained to recognize mental health symptoms as well as their treatment options. Newcomers may not necessarily want to recount their stories to me due to trust, confidentiality and secondary victimization reasons which can cause recurring feelings and symptoms of trauma; perhaps most importantly, I am not trained to counsel individuals who are recounting their difficult moments. Interviewing newcomers about their treatment would have carried a high risk of re-traumatizing them and I am not trained to deal with such situations.

3.2 Interview Process

I developed an interview guide before the commencement of my fieldwork, and upon refinement of the questions, I was able to start the interviews. I contacted several organizations, psychiatrists and psychologists, as well as the community leaders and researchers from cities across Canada. Once the interview details were arranged, I sent them an informational guideline and consent form prior to the interview.

The interview began with the informed consent process, which was either read beforehand by the participant or signed or verbally agreed to on record, depending on the participant's preference. The interviews were conducted in English, French or Arabic and the participants were assured them their responses would remain confidential and that their names and identifying information, such as their employer, would not be associated with the findings.

The interviews were conducted in quiet places, usually in the interviewees' office or over the phone. The interviews also varied in length, ranging between twenty minutes and almost two hours in length. The questions were asked in English and the participants answered in their language of choice. The questions collected information on the interviewees themselves, their background and work commitments and general information their clients or patients as well as any trends observed. I used probes and prompts to accompany the questions to further explore the responses given and used a flexible approach in my line of questioning to ensure that the interview flowed smoothly.

In preparation for the interviews, and as part of the research, I consulted the organizations' websites, programs offered, and documents provided to determine what services offered in the Ottawa area. The Talbet Orgnization that was consulted maintains an informative website with services listed that aid in all aspects of life, including: settlement and integration services, education, mental health counseling, English language skills, and employment workshops, among others. This organization services over 10,000 immigrants yearly, in over 50 languages. The top funders of this organization include Citizenship and Immigration Canada, the provincial Ministry of Citizenship and Immigration, Ministry of Community Safety and Correctional Services as well as other government and local organizations. The website publishes e-newsletters, 5-year strategic plans, newsletters and annual reports; which were all consulted for purposes of determining how the services and programs have been implemented to reflect the current population.

The second organization that was consulted is a social services agency that works in partnership with other immigration services and is part of a coalition serving this particular population. They are funded by Citizenship and Immigration Canada and the Ministry of

Citizenship, Immigration and International Trade in Ontario. The sources I consulted on this website include events and information sessions held, the annual general report, financial statements and the program descriptions. They offer services in over four languages, both onsite and offsite, and incorporate Citizenship and Immigration's tools as a component of the settlement and integration processes. The onsite services are free of charge and include weekly sessions with legal representatives, settlement counselors, social service workers, and a credential assessment specialist.

3.3 Positionality

The interest in refugees and resettlement in a new country, specifically in Ottawa, comes from my own family's personal experiences. My parents fled from Lebanon to start a new life in Canada and eventually settled in Ottawa, and began a difficult experience or rebuilding their lives and reintegrating themselves into society. Having both been university-educated, they were able to pursue further education to find employment to support their family – but it was a struggle to get to that point. They experienced difficulty with regards to obtaining 'Canadian experience', language barriers even though they were fluent in English and French and most of all, they experienced the difficulty of being away from family, friends and a country in which they had lived comfortably and happily.

The difficulty of fitting into a new country, especially with different cultural norms and expectations was presented in every aspect of my parents' lives and they worked hard to find a balance between the two. They experienced many different emotions and struggles and managed to provide an exceptional life for us, their children. This is where my interest in organizations that help the Middle-Eastern community in the same situation comes from. I am interested in knowing what the NCR offers with regards to helping refugees in such a

critical and vulnerable period in their lives when they need support with adjusting to a new country and with the feelings or mental health symptoms that can be associated to such a life-changing experience.

3.4 Limitations

As with all studies, there are limitations to this study. The first is related to a relatively small sample size. The researcher was unable to find more counselors, psychiatrists and psychologists available for the interview who had worked with Middle-Eastern newcomers with traumatic pasts located in the NCR and Toronto. The second limitation was in relation to the counselors interviewed from the organizations. While they were able to describe and recount instances of mental health disorders and how they overcame them, very few were clinically trained or licensed in using psychiatric methods or psychotherapy on others. Finally, the literature available examines case studies from conflict zones across different countries globally, and while this provides a solid background for my research, these others may have different cultural characteristics, and so may not be representative of my population of study, Middle Eastern newcomers. Having reflected on these limitations, suggestions for future research would include examining a specific profession, whether it be only psychiatrists or only organization counselors, to determine what therapies they use which will offer comparable information on the effectiveness of their practice. A third limitation arose at the beginning of the study from the decision made not to interview the clients or patients themselves. This was made in order to ensure that they were not put at risk of re-traumatization. As such, the study reflects the counselors' experiences with their clients and their recollections of trends, situations and issues raised. This was mitigated by validating the interviewees' experiences against the material on their

organizations' websites, and other publicly available information, as well as my own personal background within the culture.

Chapter 4: General Issues of Resettlement and Adaptation

The reasons for migration can have an effect on an individual's mortality rate (Gabriel et al., 2011). When compared to other newcomers, refugees have a higher age-standardized mortality rate, which can be attributed to a number of factors including their pre-migration experiences and exposure to war, abuse, trauma, and others (Gabriel et al., 2011). Newcomers generally demonstrate a higher standard of health than their Canadian-born counterparts, also known as the "healthy immigrant effect", measured by mortality rates, the prevalence of chronic illnesses and self-assessments of their health statuses (Health Canada, 2010). However; those among them who are identified as refugees tend to have a higher age-standardized mortality rate, which can be attributed to a number of factors including their pre-migration experiences and exposure to war, abuse, trauma, and others (Gabriel et al., 2011). These stresses make it essential for those who have been exposed to violent conflict to receive appropriate health care services upon arrival and overcoming the health-related obstacles to proper settlement (Gabriel et al., 2011). These barriers are found in all levels of the resettlement process: on an individual level, with difficulties associated to language, financial implications, stigma and mistrust and lack of access, and on the provider level with lack of funding and resources and the lack of culturally-appropriate services and training (Gabriel et al., 2011). This process also requires the assistance of social services to aid in daily tasks for establishment purposes such as obtaining a driver's license, applying

for a Social Insurance Number (SIN), obtaining a provincial health insurance card and credit cards.

There are barriers to social services based on the misconceptions related to the departments that fund them and the perception of connectivity between the two. The perceived barriers are due to the fact that the government departments that fund these organizations are the same departments associated with processing and granting citizenship applications, and the same government department that is responsible for revoking visas and residence permits. These pre-migration factors, the barriers to resettlement and treatment options will be discussed further.

4.1 Reticence about disclosing personal information

The ability to recall and discuss painful or difficult experiences and memories differs from person to person, and culture to culture. There are many internal and external factors that contribute to the level of comfort with or reticence about disclosure.

The counsellors, community leaders, and physicians that reported that in many Middle-Eastern cultures, there are circumstances where shame is associated with talking about something of a personal nature. Along with shame, some individuals will experience embarrassment, and will most likely discuss their experiences during individual one-on-one sessions rather than the group sessions. The feeling of shame may be related to expressing something that is socially unacceptable, such as having to seek mental help services because the individual is unable to resolve the situation on their own.

The literature suggests that when certain beliefs and customs are universalized and repeated, they dominate cultural practices in that given society (Awwad, 2001). This applies to what conditions are stigmatized, including mental health illnesses. Seeking psychiatric

care has fallen into the category of unacceptable practices, according to the counselors recounting their patients' beliefs. As witnessed by the counsellors, after sharing these sensitive experiences, patients/clients become embarrassed because now a whole group of people are aware of their feelings; the fear of this public disclosure is reported to be why counsellors believe it is easier for clients to divulge them to the counsellor in an individual therapy session.

When discussing any mental health issues or symptoms, the patients or clients do not directly bring up their concerns, according to several counsellors interviewed; rather, they will bring them up under the guise of another issue. For example, counsellors reported that patients may discuss their difficulty sleeping or the inability to study for their citizenship test, which will allow the counsellor to probe further into the underlying reason behind these challenges.

According to Amanda, an Iranian therapist in Toronto, Iranian women who sought services from her tended to look at and accept their trauma as a lifestyle, "just something that they have to live with". These women have expressed to Amanda that by living in a Canadian society, they feel safe because they do not expect to be questioned or blamed for perceiving themselves as a "victim" – which differs from their experience in Iran. But these women feel safe talking about their past because they are in a Canadian society and because they will not be questioned or blamed for being the victim, which is not the case in Iran, according to the therapist. And because of Amanda's own cultural background, which many of her patients shared, they felt safe and comfortable discussing certain life issues which would otherwise be deemed 'taboo' in different circumstances.

The counsellors from Prescott Organization all claimed to have faced situations where some of their clients use these past experiences to gain pity from others. According to counsellors, these same individuals will pretend to have mental health disorders such as PTSD, concentration problems, and depression and say that they cannot attend any classes or study. Counsellors described incidents in which their clients will claim that they are unable to perform certain duties or tasks (e.g. work, write the citizenship test, among others), yet throughout the same sessions, they will describe to their counsellor how they were able to participate in certain analogous activities and social events. This contradicts their capacity for performing certain tasks, because they claim they are unable to do it for one thing but can do it for another. This selectivity for certain tasks also supports the counselors' claims that the newcomers express a sense of entitlement and expect the counselors to perform many job-related and daily tasks for them. This leads to the counsellors becoming sceptical of the clients' claims that their mental health disorder prevents them from doing things.

In one of the organization's group workshops, one of the counsellors tried to encourage the participants to overcome the feelings of helplessness by showing them a calendar in which an amputee woman without any arms or legs painted the monthly pictures. She used this to show them that they can overcome any physical or mental obstacles in life.

With regards to the students experiencing difficulty due to their past experiences, they also need to have an element of trust present, according to all the therapists and counsellors interviewed. Nonetheless, the students are very cautious with the group they share their experiences with because some other students may not support them and may even feel traumatized or stressed themselves from listening to them. The teachers and counsellors found in the school need to ensure that there is proper support afterwards and that the student

is not left alone after having opened up to others, according to one of the researchers. According to Sarah, children also experience reticence with disclosing personal information, because they are cautious not to represent their families in a negative way.

Based on ten of the participants interviewed, while the issue of trust is an important factor to being able to discuss past traumatic experiences and work to treat the mental health disorders caused by them, it is often reportedly easier for people to trust their religious leaders than the counsellors initially and throughout the process, depending on the situation. Trust will eventually develop in most cases with the counsellors. However, religious leaders are initially seen as a beacon of hope and someone to rely on through difficult times and are often approached after the religious service for private individual discussions regarding their issues. Counsellors report that some clients do not discuss their past vocally but they will express it on paper when filling out any forms, as needed. An example of this is when women do not talk about being sexually assaulted for fear of ruining their reputation.

The use of prayer and discussion with religious leaders is highly regarded as an acceptable outlet for stress and problem-solving. This is partly due to the religious aspect of their profession and that the newcomers feel they are able to open up to someone who represents their ultimate beliefs, without as much fear of being judged. This perception plays a strong role and it is seen when they approach the priest or the Imam with a variety of issues. They already believe that the religious leader will help them, and this sense of trust is already developed, whereas this may not be the case for their counsellors, even though they may be from the same cultural background.

4.2 Fear of Deportation

One of the recurring themes throughout the research is the risk that patients feel in disclosing personal information to counsellors, social services and medical professionals for fear of being deported from the country. This was raised by all the counsellors, physicians and researchers interviewed,

This is an important distinction to note because the newcomers who are seeking services are aware that these services are government-funded and believe that this link will result in having their information disclosed and possibly in being deported from Canada. This fear of drawing attention to themselves was a recurring thought with these families, as they were under the impression that they may be deported from the country for any reason, including not being mentally 'stable' and having to seek treatment, as noted by Sarah having worked with children in her research.

4.3 The Effects of Demographics on Resettlement

Throughout the interviews, the counsellors saw newcomers from various countries including: Afghanistan, Algeria, Djibouti, Iran, Iraq, Jordan, Lebanon, Morocco and Palestine. All interviewees noted that certain behavioural trends were specifically exhibited by either men or women. Although the majority of observations apply to these trends, the counsellors have also made it clear that not all newcomers adhere to these patterns.

4.3.1 Interviewees' Observed Behaviours in Women

Several counsellors from both Ottawa organizations stated that women tend to adapt and settle into their new surroundings better than their male counterparts. This is partly due to their sense of purpose in life by committing to the role of caring for their families. Along with this sense of purpose, women may find themselves entering the job market to support

their families. This shifts the family's dynamic because the woman gains financial power/independence. The literature suggests that gender roles are integral in making important decisions related to migration; including: if and who in the family will migrate and if it is done on a permanent basis (Pedraza, 1991). Ultimately, these decisions rely on the hierarchy of power in the family unit (Pedraza, 1991), which can be destabilized when newly defined gender roles take effect. In the case of women who were financially dependent on their spouses, the process of emigration allowed them to obtain employment and contribute financially to the household which resulted in a newfound sense of independence. (Pedraza, 1991).

According to the counsellors, while these changes, along with rapid settlement into society and the job market allowed the women to gain independence, they also result in the woman feeling stressed, overwhelmed, co-dependant on their partner and anxious because, they are preoccupied with caring for others and lose the ability and time to care for themselves.

The counsellors and one of the religious leaders also state that women from some Middle-Eastern countries may be more "conservative" in general, and believed that this may be one reason as to why they were less likely to pursue counselling services. This was echoed by Albert's experiences with the conservative nature of his community members. If the women do, however; seek counselling, they are more willing to express their feeling than men and are more willing to improve their emotional and psychological situations.

4.3.2 Interviewees' Observed Behaviours in Men

According to almost all the counsellors, men undergo a process of re-identification after arriving to Canada with a large portion of this change being due to their new role in the

labour market (see also Casey and Dustmann, 2010). Having previously identified themselves as being strong, protectors of their loved ones and the main family provider, they experience difficulties in Canada as these gender roles may not necessarily apply. Many Middle Eastern males feel that they held the 'alpha' position and are now accepting employment that is below their status, achievements or profession. As described by the Imam, men who have been living successful professional lives come to Canada to work as a pizza delivery person or a taxi driver, which affects their self-esteem of being a provider for their family and having to start their professional life over again. Having said this, once they receive an opportunity, they take it and start working – regardless of what the job is. This can be seen in individuals who are unable to learn the language so they opt for physical work and employment in technology, but they accept the fact that they cannot move past this level of employment.

Many individuals also become self-employed in the retail or restaurant industries (Borjas, 1986) as this route is often taken to attain higher economic mobility (van Tubergen, 2005). This realization that they cannot move forward causes frustration. Counsellors must continuously encourage newcomers to continue to be proactive, motivated and patient – especially when they are unable to see the results in the short term. This psychological stress will cause men to experience mental health disorders more rapidly than women according to the counsellors, however; they will not seek help as they want to uphold the masculine ideology of being strong and fearless – deterring them from seeking psychological help. According to the interviewees, they will continue this lifestyle until they have reached a point where the stress becomes so severe that the only option becomes seeking psychological services. Overcoming these barriers, specifically employment and seeking settlement

services, will improve mental health illnesses (Mixomova & Krahn, 2010). This is supported in a previous study, where newcomers rated their own mental health as having improved because they were no longer experiencing war, genocide or political and economic crises (Mixomova & Krahn, 2010).

4.3.3 Age

According to the interviewees, age plays a role in the resettlement process as individuals are able to cope and understand situations differently based on the different stages of life they find themselves in. Children, especially, are faced with learning environments within an academic setting as well as in their homes, increasing their exposure to language and literacy learning (Li, 2007).

Consensus throughout the interviews indicates that the younger population of newcomers are better able to cope with the difficulties associated with the migration processes. There are many factors associated to this coping including the fact that the younger population have not experienced the loss of their careers and educational value upon departure from their homeland. They are also presumably in school, which results in constant social interaction with students and teachers; this allows them to improve their language skills through communicating with others – alleviating one of the greater burdens/obstacles experienced by their adult counterparts.

According to the counsellors, children experience initial challenges with the language and can be shy at first. Many children are also attending school for the first time, and the process of acclimatising to the academic and social challenges may lead to feelings of loneliness and difficulties with integration.

Cultural identity will also play a role in this process, as youth are not as attached to their native culture as their parents are. According to four of the counsellors, children experience feelings of being 'in-between' their homeland culture and their Canadian culture, causing feelings of confusion and uncertain of how to behave and comply with the cultures. This results in a constant feeling of being a newcomer or immigrant. Part of this confusion is due to the fact that younger newcomer patients are surrounded by and influenced by their peers and surroundings and this may lead to a different set of influencing factors that need to be accounted for (see Cohon, 1981).

According to Amal, Sam and Sarah, this cultural confusion may contribute to high rates of delinquency. This may include involvement with drugs, underage drinking, gangs, as well as incidents of bullying in a school setting. Many youth find themselves in youth detention centers with feelings of being lost and not accepted. Adolescence can be a difficult time for all youth, but particularly for newcomers because they experience phases of unresolved conflict, mistrust, and will question their ability to be autonomous and successful and their overall identity. This surge of contradicting emotions may cause the adolescent to struggle internally with showing loyalty to different aspects of both their original culture and Canada's culture (Eisenbruch, 1988).

Sam described a situation encountered by one of his family clients that experiences this bicultural confusion. This family moved from the Middle East to Toronto, and the woman (who was veiled) began to adapt the Canadian customs and replicated what she saw in Canadian women, including the freedom to abandon parts of the traditional gender role, which the husband disagreed with. He left his wife and she began dating a man who moved in with her and her daughter and did not treat them well. The daughter became very

confused because, in the culture of her country of origin, it is not customary to move in with a member of the opposite sex before marriage. The daughter is also faced with the fact that her father left her mother because he was deeply entrenched in his culture and customs and did not agree with her newfound way of living. This confusion, along with the pressures of learning the language and succeeding in school imposed great pressure on her.

A similar experience was faced by one of Amanda's patients, who explained that she was found great difficulty with living under her family's traditional customs as well as the host country's cultures; she faced the risk of alienating herself from her family based on the lifestyle that she chose to live. The services provided included discussing these issues with the family in a combined therapy session to work out the issues and how the family and the daughter could work a compromise in terms of lifestyle choices and decisions.

Children also face psychosocial challenges, environmental challenges and educational challenges and are generally faced with feelings of loneliness, family separation, and loss. They may also have experienced torture and/or have witnessed war, rape, murder and amputations, among other tragedies. This two-sided way of life, being defined by and adapting to two cultures and customs proves to be difficult for the children and affects their parents as well, causing them all a feeling of loneliness, as described by two organization counsellors and one of the therapists interviewed.

According to a Sarah, who studied newcomer children, the educational system does not know how to manage this dualistic lifestyle and has difficultly educating them, as do their parents. The students tend to gravitate towards other students of the same culture or nationality, except in situations that such as sports or clubs where they will mingle with other students. Research shows that community support is also important to helping

newcomers overcome these feelings by continuously being exposed to familiar and similar social events (Cohon, 1981) – for children, these begin with experiences with their mother and then expanding their social network to other environments and situations.

4.4 The Effects of Nano-Systems in Educational Settings

It is important for children, as well as adults, to be provided with a solid support system for the migration process. As noted by Sarah, a researcher who was interviewed for this study, the support system is an integral part of a child's development and can be found through schools and teachers. According to Sarah's experience and research in this field, these micro-systems are based on the relational interaction between a student and a teacher and help the students feel like they belong in the school system. In their positions, the teachers are able to observe the students behaviour and schoolwork and will approach the student based on the 'hints and glimpses' of their experiences shown through their writing, story-telling or through behaviour patterns including anger and performance issues. By exploring these 'hints and glimpses' further with the students, the teachers are able to discuss these issues with the students and even refer them to social or mental health services, if needed.

In pursuit of her research, Sarah notes that there are instances in which students or their friends would approach the school counsellors but the services provided were under-resourced due to the number of counsellors available and the ability to address these issues. She also believes that the current model of talk therapy was not effective with this population of newcomer children and students.

According to Sarah's observations, high school students were reticent with disclosing personal information regarding their mental health. They did not want to admit to having

mental issues and did not want to be labeled for several reasons, including having people think that there was something wrong with the family or out of fear of being deported since the mental health service providers are funded by the Government of Canada. She told of instances where the parents or caregivers would decide that the student did not need help, which she also suspects was affected by the fear of deportation.

4.5 Family Dynamics

A family support system is important for newcomers and integral part of the migration process, as mentioned by several counselors throughout the interviews and supported in the literature that suggests that family capital can have positive impacts on both the parents and the children (Li, 2007). The family unit can provide support in three different ways, physical or financial capital, human capital and social capital; which encompass material resources, social behaviors in different environments and relationships within the community (Li, 2007). This can have impacts on the children's capacity to learn, the family's home language and literacy environment as well as the different interactions had within the family unit (Li, 2007). This support system can be found through various groups: family, friends, a religious institution, a political party or the cultural community.

When both the parents and children are coping with the same issues, it becomes difficult to support each other within the family unit, according to the interview data. When the students are facing these psychosocial, emotional and educational challenges along with coping with the stress of living in two cultures, their parents trust the school to handle the issues and do not get involved and are cautious about drawing too much attention to themselves, according to Sarah. According to the counsellors interviewed, there is often a shift in power to the children, who have learned the English or French faster than the parents

have (see too Qin, 2006) and whose parents now depend on them for cultural and linguistic translation. The children undergo difficult changes both in their households and in the school settings. In their household, the children are aware of this power shift in their favour and yet in the school setting, the newcomer children may face bullying and rejection, which can lead to greater isolation. The acculturation gap between the parents and children is one of the greatest contributors to this shift in family dynamic and can lead to conflicts between them (Qin, 2006). The family also faces pressure from their communities, who expect them to carry out traditional customs, even though it may be beyond their means, for example living in a big house or having a large wedding for the children. According to Sam and Sarah, there have been some cases in which the children who leave may end up in prison, and this may cause even greater stigma to the family. The way the family copes with this transition can make a huge difference. Those with a strong family unit, who have overcome the generational and cultural gap and have adapted to a new way of thinking, have had greater success with adapting to their new environment, according to the counsellors and researcher (Li, 2007). This finding reflects the research that describes the importance of the roles played by each individual, especially in a family setting with regards to a shift in power and ability of the children to learn the county's language faster (Li, 2007) and the women's ability to contribute financially. This power shift and having to build one's educational and professional life is a difficult process of de-socialization and re-socialization (Cohon, 1981), causes additional stress.

According to one of religious leaders, the pressure that newcomer families face from their families back home also contributes to stress. Family members from the countries of origin frequently assume that the newcomers are living a more prosperous life in Canada,

though this is not always the reality, especially at the beginning. This pressure can all lead to a shift in the family dynamic and the traditional family roles undergo a change. These changes may lead the children to leave a family unit.

As observed by Sam and Amanda, newcomers who arrive to Canada and without a family community may experience feelings of freedom and conduct themselves in ways that may otherwise not be accepted in their home country. According to Sam, this is because they are unknown in the country and do not feel accountable to anyone, therefore; do not feel that the community will report their actions to their parents. Sam continues to state that one of the most prominent questions asked by individuals from Middle-Eastern countries is who the individual is related to because it is custom for these connections to play a role in life activities, such as applying for a job or a program, and to obtain certain services. Those who feel that they are not accepted by their host country, who have a break in the family where the children's relationship with their parents is hindered, and who find themselves on their exterior of their community are unable to overcome the obstacles (especially if they do not have any family or friends in the country) and often return to their home country, as described by Albert. This supports the literature that suggests that the host country needs to be primed for growing changes in their population and need to reduce discrimination or prejudice against the new newcomers (Cohen, 1981). In the case of children and the education system, Canada must be wary of creating a social climate in which students are exposed to discrimination and prejudice, in part because this will affect their children's overall behaviour (Ma, 2002) but also of course because such discrimination and prejudice are unjustifiable and fundamentally unjust.

Many newcomers face difficulty after having visited their home country because they realize they 'do not fit in' financially, socially, or psychologically anymore; this may actually help them adapt better in Canada, as noted by one of the religious leaders. This difficulty with 'fitting in' will lead to complaints and laying blame on Canada and even the families that sponsor them and they have to overcome this mindset and learn to be patient and work hard. According to a counsellor, once this is understood, newcomers will they become appreciative for what they have.

These factors not only cause, but also exacerbate, any feelings of mental health disorders and if proper treatment and help is not delivered, it can have potentially detrimental effects to a person's future. When discussing whether or not newcomers seek services alone or with someone else, several counsellors noted that young single women will seek support services with someone from their family, especially at the beginning. As described by an organization counsellor, the family plays the role of a 'buffer' and will help each other with any problems, issues or situations that one may face. As described by counsellors and the religious community leaders, this is not limited to the immediate family, but to the extended family as well. Sam described an example where someone found themselves in a situation where a child's parents was unable to afford a university education, the uncles and cousins helped them financially – and this is a regular expectation. Families tend to come together, especially if they feel that all family members will benefit from receiving the same information.

Chapter 5: Therapeutic Models from a Clinical/Rehabilitative Perspective

5.1 Therapies and Treatment Options

This section highlights the interviewees' depictions and opinions of the therapies and treatment options used as well as those voiced to them by the patients and clients themselves.

Matt describes mental health disorders and their symptoms as being able to improve with mediation or intervention methods, regardless of the therapy techniques being used. It is imperative that the individual have a support system in conjunction with the counselling methods that is not limited to the psychiatrist or counsellor. This ideology is further supported by the World Health Organization's model for mental health service, which outlines the importance of involving the patient in their own mental health care as well as having secondary care components to assist the primary health professionals through support, supervision, and referrals (WHO, 2008). This model includes involving community-based services and informal services because "no single service setting can meet all population mental health needs" (WHO, 2008). The community mental health services can include rehabilitation services, therapeutic and residential supervised services, assistance to families, among others (WHO, 2008).

Although different personality and cultural traits can span various origins, it has been shown throughout the interviews that family, community, spiritual leaders, and other members of society play a significant role in an individual's life. This importance must be incorporated into the care that is provided for them (WHO, 2008). The literature further supports this notion of incorporating community care to elicit a better quality of life over the individuals that have been treated in psychiatric hospitals (WHO, 2008).

5.1.1 Group Sessions

Group sessions are offered to unite people together that have similar or different backgrounds, issues, concerns or goals. According to Nancy, Ester and Molly, these sessions are an effective way to communicate information to a large group of people simultaneously. The counsellors use these forums to discuss a broad range of topics including: citizenship tests, family law, health issues, women's empowerment and even to conduct self-defence workshops. The experiences are shared in a neutral and objective environment, and sensitive topics such as religion and politics are avoided. While this is an open forum, counsellors have noted that the clients may not initially feel comfortable; therefore, trust exercises are conducted to build a comfortable relationship with the other members and the facilitator. The organizations measure the effectiveness of these sessions by participation rates and feedback as well as success rates on the citizenship tests.

The counsellors are also able to observe the group dynamics in these sessions and have noted that the majority of participants tend to be the 'followers' and will follow the main reaction of the group. The opinions shared by the clients regarding the group session focus on the fact that they are able to find all the information provided themselves, yet they use these sessions as an open forum to share their concerns or frustrations with others.

Another observation made by Nancy is the resistance felt by the participants regarding the work that must be completed (e.g. building a resume or applying to jobs) and that if they are being referred to other services, they are not receiving adequate care. Many of her clients expressed discomfort with the teaching methods used, including computer and language skills development because their own specific needs are not addressed. This is an interesting

point because is parallels the premise of having psychiatric care that caters to the population's needs. Another indication of discomfort found amongst the older participants is the interactions with the younger population (and sometimes women) in the group, which led to the creation of women-only group sessions.

There may be conflicting opinions in these sessions, particularly when related to sensitive topics such as politics. In these situations, some participants maintain a sense of patriotism and can come together as a group to defend their home country.

5.1.2 Family Therapy Sessions

Among those interviewed, nine of the counsellors were involved in family therapy sessions and consider that these sessions are beneficial for families who are experiencing the same feelings and issues, and it is effective for observing the dynamic between family members. It is also important to accommodate the children who come to the sessions with the parents, because the culture requires that the counsellors do accommodate them. These family therapy sessions are important for a child's coping because a supportive family unit is an important factor to building and increasing resilience, along with a positive personality and an external social support group (Eisenbruch, 1988). In the group workshops for the women run by one of the Ottawa organizations, they would bring their children and the center had to accommodate them as per Ester and Molly. The children would interact and play with each other in this environment with other families that speak the same language and practice the same customs.

5.1.3 One-on-one counselling

The counsellors stated that the clients tend to prefer one-on-one sessions because they are given a space where they can be heard, can cry and can vent and where they are able to trust that their information will be kept confidential and not be judged by the counsellor. According to Nancy, the clients seek support in the form of an open space to freely express themselves emotionally. As the counsellors are able to satisfy these needs, referrals to clinical mental health services are rare.

The counsellors know that they must be cautious when introducing sensitive topics such as religion, politics or past experiences of war or trauma in the discussions with clients; the counsellors cannot just bring up issues that might leave the patient re-traumatized. According to the counsellors, many of the patients have expressed discomfort with direct one-on-one discussions, particularly if they have undergone difficult experiences and they may have reservations about full disclosure, especially in a second language. According to Amal, patients will initially feel pressured to attend the individual sessions with a family member and they are too ashamed to say no; there are also instances where they become upset if the counsellor asks to see them without their spouses. According to Nancy, other dynamics of one-on-one session include the resistance initially felt towards the facilitator if they may be too young and they don't trust that they are experienced enough. Mark further explains that victims of sexual abuse will take longer than other clients in terms of treatment time, 20 sessions versus the regular seven to eight sessions.

But the fear of being judged by others, especially those from the same culture, can also deter individuals from seeking group sessions and lead them to opt for individual sessions instead. Counsellors state that their clients prefer one-on-one sessions because it is more personalized to their issues; once a sense of trust is developed with the counsellor, they are able to discuss sensitive topics with them. Many factors contribute to the avoidance of group sessions with individuals from the same culture. Patients who have been traumatized in their country may avoid settings where they are exposed to people from that culture because there is a deep sense of mistrust towards them. Another issue relates to the cultural taboos associated to discussing certain issues so individuals will avoid environments where they may be judged for their mental health illness. Trust needs to be established before individuals can freely discuss their traumatic experiences and this cannot be achieved with a group of people whom they do not know. Counsellors have also raised the issue of some Middle Eastern families opting for privacy and not sharing their personal issues with other members of the community; this will deter them from partaking in a group sessions where they risk having their information passed on to other families and members of the same community, especially since having a good reputation is very important in their culture.

According to the interviewees, the clients have expressed preference for having a counsellor who is part of (or who understands) the clients' culture and prefers the individual therapy format because it decreases the feelings of stigma found in a group session. Upon researching the organizations' websites, this issue must have been noted and addressed, because one-on-one counselling sessions are offered as well as a wide range of counsellors with different cultural backgrounds. By having a choice of counselors from different cultures, the organizations are responding to the newcomer population's need for

incorporation of their beliefs and traditions and this may lead to greater perception and communication of the issues discussed, based on a shared understanding of the culture.

5.1.4 The Case of the Life Story Board

The Life Story Board (LSB) was created Dr. Rob Chase in 1995 (LSB, 2012) as a way for patients to share their experiences in a non-verbal way The LSB is comprised of several components representing different life experiences: personal qualities and issues, family and close relationship, larger community/world, and timelines (LSB, 2012). They are all used on the board to construct the patients' experiences involving their feelings, situations lived, and relationships with family and community members without have to verbally express themselves.

Counsellors, schools, therapists, mental health clinicians, Children's Aid caseworkers, use it as well as counsellors working with First Nations Youth who have been criminally involved. Dr. Chase first used it in Sri-Lanka with children, and therapists in Manitoba are now using it. His colleague, another physician who was interviewed, is conducting a pilot project with the LSB with adults in the Ottawa region, which is still in its preliminary phases without any results as of yet. Originally, the LSB was used by occupational health workers with new Canadians and non-English speaking workers, and it has become a way for them to communicate any misgivings that have happened to them – experiences that they would otherwise not discuss because they are not yet aware of their rights. Therapists use the LSB in a pilot project with children who have experienced traumatic events.

John describes the LSB being an effective method of therapy because there are many non-verbal aspects to life and the LSB provides a way to describe how patients look at the world and their feelings inside. Some therapists use it at the beginning of a treatment process with

their patients and others wait until trust has been established, which usually happens several sessions into their treatment.

With new Canadians and people from cultures who do not speak English and who have trouble with basic English literacy, there is a double disadvantage because the only way they can engage with a therapist is to articulate it in a second language and even then, words do not capture their experiences as well as possible. Compared to other art therapy processes, the LSB is unique because it provides a structure for all aspects of narratives in a loose symbolic form, allowing patients to externalize their experiences, according to the physician that created it. The tool is a multi-dimensional genogram, because it goes beyond displaying family members and their medical history. The LSB displays family relations and their behaviours alongside events in their lives, such as war, and highlights how the patient felt during each event and with each relative.

According to Dr. Chase, counsellors reported that, while the patients found the LSB to be a helpful tool, some of them were in shock to see what a 'mess' they were in. That helped them disclose their experiences and it attributed to the externalizing visual process. In another context, the patients expressed discomfort when using the LSB the first few times, but as they become more familiar with it, they became comfortable using it (Medina, 2014). There were instances where the patients disclosed past experiences for the first time in their lives, and the LSB opened up channels to visual and verbal communication with the therapist (Medina, 2014).

This demonstrates how health care providers involved in my study have adapted their therapy methods to accommodate a population that has lived a difficult experience and is unable to discuss it openly. It also allowed them to visualize their experiences in an

organized and chronological manner (Medina, 2014). Not only were the patients able to remember the events from their past, but they were also able to project themselves into the future (Medina, 2014).

According to John and the website, the LSB's use has expanded to be included in adult therapy sessions and has been used with community mental health therapies, in family services, grief and trauma counseling and with the immigrant and refugee population (LSB, 2012). Its growing use across Canada, and internationally, has demonstrated how the Canadian health care system uses innovative therapeutic methods to transcend cultural and language barriers across different ethnics groups, age ranges and patient experiences.

5.2 Barriers to Counselling and Treatment Options

It is important to understand the link between pre-migration experience and overall health for newcomers because they usually have better health and lower mortality rates than native-born Canadians (Beiser, 2005). However this high standard of health is jeopardized if they do not undergo proper resettlement (Beiser, 2005). If the issues are not dealt with, individuals can carry problems with them to Canada and in some cases, the problems can worsen. Studies in Alberta show that those who had greatest declines in their mental health upon arrival had either spent time in refugee camps, maintained professional or managerial employment, or who had a university degree in their country of origin (Mixomova & Krahn, 2010).

There are many barriers to newcomers getting the counselling that they need. As discussed by all the professionals interviewed, the identification of these barriers can facilitate treatment and ensure clearer understanding of the patients' needs as well as the creation of programs required to satisfy them. According to the interviewees, the following

barriers are common: difficulty learning or understanding the English language, unfamiliarity and discomfort of seeking a clinical health care professional, difficulties with finding employment opportunities, and finally, the lack of knowledge of the Canadian society.

5.2.1 Language barriers

The language barrier has been recognized by the counsellors interviewed from both Ottawa organizations, and from their experiences, clients are able to overcome this barrier with counsellors who speak their native language and are better able to communicate their issues, struggles and expectations than if the sessions were conducted in English or French. As such, both organizations have programs and counselling offered in a variety of languages, and have employed counsellors who speak several languages to accommodate the population of clients served. These services are promoted through their respective websites and the existence of such services has been validated throughout the interviews. As mentioned above, one organization conducts its programs in over 50 languages and the other organization employs counselors who can converse in four languages.

Language interpretation is also a key component to any treatment and should be considered by both the patient and the therapist. According to four counsellors, the interpretation of the spoken language must be considered in cross-cultural psychotherapy and encompasses a greater understanding of the meaning of the words and expressions used because it becomes difficult to translate them directly and properly. Sam spoke of a client's experience appearing before a judge as he was defending his use of corporal punishment on his son as a disciplinary measure to ensure that he stopped bullying others in school. In justification of his action, the client explained to the judge (through the use of an interpreter)

that he "does not throw a stone in the well that he drinks from". The use of parables is very common in his culture and the client assumed that the judge would understand his point, an assumption that was not applicable to the situation. According to Sam, his parable represents the client's fear of jeopardizing the new life he was given in Canada (the well) by having a son that was causing problems in the community (throwing the stone). Given that the use of parables is not as common used in the society, the judge questioned the aphorism as well as its relevance to the hearing and explained to the client that all questions in court must be answered with a direct response.

5.2.2 The Appropriateness of Techniques and Interventions Used

Some health care providers deem the traditional psychotherapy intervention techniques to be adequate to meet the cultural standards of newcomers; whereas others consider it an inappropriate response to their mental health issues and interconnected beliefs of medicine and culture.

A common stigma amongst the cultures found in the Middle East, as described by the counsellors from both organizations, is the stigma against seeking psychiatric care because it equates to madness in the eyes of the community. From a treatment perspective, as described, the counsellor faces difficulty in administering effective care due to this stigma. Since this view of mental illness being regarded as synonymous with irrationality persists, stigma reduction strategies are imperative (Ramon, 2009). Furthermore, the greater emphasis on psycho-social intervention methods and the use of a range of psychological and social support might help reduce this stigma and allow the client to choose the best option of themselves (Ramon, 2009). The patients are in a situation in which they must overcome this culture as well as building and fostering the trust in their community, system and

environment because it has been broken as per their previous experiences. This broken trust affects the patients' coping mechanisms and analyzing systems and given the fact that trust is the primary element that fosters an environment conducive to disclosure and recounting past experiences; their lack of trust thus becomes a large obstacle to overcome. As per the counsellors interviewed, these trust issues contribute to a patient's avoidance of care from providers that originate from the same country – this cycle of avoidance is paradoxical as the patient is avoiding care from individuals whom they might best relate to.

As mentioned by Amal, one of the issues with the psychotherapeutic intervention methods used in North America is the fact that it does not now account for the patient's culture, which plays a large role in the treatment process due to their beliefs, customs and language that need to be incorporated in the therapy. She also states the importance of introducing trans-cultural psychotherapy methods to ensure that these cultural preferences are accounted for. Examples of incorporating trans-cultural components into the therapy sessions include removing any religious symbols from the room and from her attire, researching the client's culture to understand the different customs, such as the veil or the religious books used.

Furthermore, the techniques and tests used are not always applicable to the population of newcomers arriving to Canada. Amal relates their concerns with the regards to the validity of the psychological tests used in the Canadian health care system and if they apply to the newcomer Middle-Eastern population as they were designed based on a certain norm of education and beliefs that may not apply to patients universally. These tests must undergo constant review and adjustments to ensure that they meet the needs of the population. Amal described the use of the Rorschach test as an example of a psychological tool that was

designed for European - North American cultural norms. He said that Middle Eastern newcomers do not understand the premise, meaning or significance of the test.

Ester and Molly described a situation that occurred in the women's group programs in which mothers would attend the session and bring their children unannounced, expecting the counsellors to accommodate them. This is the norm in their culture and not accepting the children in the session would be "far from God". This expression is used and understood in the culture to describe the values of hospitality that were expected, and it has nothing to do with the distance or the relationship that the counsellors have with God. This emphasizes the importance of the religion because it exemplifies the different cultural norms and the need to address them. In the situation above, the counselors accommodated the clients' needs and allowed them to bring their children to the sessions because they realized that this was an integral component in their participation. This demonstrates how Ottawa organizations are recognizing these cultural nuances and incorporating them into their therapy and information sessions.

As mentioned throughout the interviewees with the religious leaders, a client's religion will play a role in the treatment or resettlement process and understanding their beliefs will help with understanding their customs and practices. As shared by Nancy, there are instances where veiled Muslim women do not feel comfortable shaking a man's hand during an interview and are shocked when they are told that this is a natural expectation in Canada. Nancy also accounts for this discomfort in her sessions and finds suitable alternatives that compromises between both cultures: the women put their hand to their chest and perform a bow as a sign of respect.

The alternative ways of interacting in society and mitigating societal practices is very important because patients have expressed to their counsellors their concern with standing out or becoming isolated. The use of alternate societal norms will help the patients with the stigma of pursuing mental health services because they do not want to relate the anxiety, sadness and isolation to mental health because they believe it means that they are crazy. Building trust is paramount to any professional relationship. As described by Amal, most counsellors avoid displaying religious symbols or artefacts on themselves and in their offices as such objects may become an obstacle for some patients, who are thereby unable to categorize their counsellors by religion, sect or denomination.

5.2.3 The Effects of Stigma, Culture and Religion

Several counsellors highlighted that the culture plays a role in the perception of gender roles that affects their ability to provide services to help with their resettlement. Men's sense of manhood, which is particularly emphasized in the Middle-Eastern cultures, causes them difficulty recounting their experiences to psychiatric professional or service provider for fear of being perceived as a sign of weakness. As mentioned previously, this perception is overcome when the men feel that these services are their last resort, when they feel paralyzed by this disorder or when they require an assessment for legal reasons.

An effective technique used by Ester and Molly to mitigate the stigma is to begin the group sessions with an introduction of the individuals' different cultures and practices, which allows the group to understand their colleagues' backgrounds. This became an effective method with women seeking help from the centres that have experienced domestic abuse but have been unable to improve their lives because they believed the abuse was a part of their culture.

According to Ester and Molly, they ask the women to describe their lives and whether or not they suffer from domestic violence. The result conveys that while some women do share this experience, there are some women that do not – this allows patients to realize that although the women share the same culture, domestic abuse is not a norm. In this example, the woman in question understood her situation better and was able to discuss her options for her family and their situation with the counsellor. These situations have also been faced by Amal, who addressed them by incorporating the patient's experiences and cultural perceptions, to help the patient understand her present society and compromise between her original beliefs and her newfound ones.

This relates to the mentality that some newcomers carry regarding their open-mindedness to their new experiences. According to the counsellors, newcomers associate difficulty with adapting to Canadian culture and society, and dispelling the many assumptions they have of the country. For example, newcomers have told counsellors that in Canada they need to take care of many lifestyle details and decisions (work, education, buying or selling a home, among others), which they were able to delegate to others when in their countries of origin. They said that this newfound independence and autonomy felt 'like a punishment'.

A client described to a counsellor her dislike of this freedom during a workshop, when the group was told that they needed to work and complete the objectives of the session or else they would not benefit from them. The client was taken aback and told the counsellor that the group felt should not be spoken to this way because they felt rejected and that they should be accepted for who they are. The counsellor explained to them that this feeling of rejection is a misunderstanding and they were not being judged, rather she is telling them that they have to be responsible for their future here in Canada.

According to the interviewees, this feeling of isolation, along with the language barrier, culture shock and the challenges with educational accreditation, all create psychological turbulence such as anxiety, lack of identity, diminished self-confidence and self-esteem, depression, sadness, forgetfulness, anger, and irritability. The literature suggests that the feeling of isolation may be attributed to the weak attachment to the host country, including the language, as well as having a strong attachment to their own native culture; further creating a feeling of social segregation (Cutler et al., 2008). This transition also had a negative effect on a person's skills, including a diminished ability to make a decision, lack of coping mechanisms and lower analyzing skills. Coming from a country where, for example, business is controlled by a specific religious group and where academic and government positions are reserved for another religious group, newcomers faced quite a shock when they observed how differently things operate in Canada.

There is an interesting relationship between isolation and mental health illness because an individual's mind will turn inwards and the lack of stimuli may lead the individual to feel insecure (Cohon, 1981). Conversely, studies also show that an overwhelming amount of stimuli will also cause an individual to experience feelings of insecurity (Cohon, 1981). Both of these situations have been experienced by newcomers, based on the different stages of establishing a social network and acclimating to the new surroundings. The migrant's feelings and attitudes will change if the new society provides the services needed to help them in the settlement process (Cohon, 1981) that the newcomers can utilize and trust.

Ronald continues to describe the techniques used to create trust and of becoming an approachable source of help: using logic and potential physical and spiritual rewards rather than scare tactics. Ronald markets faith in the community as a tool to distance people from

their psychological challenges. Examples of physical rewards offered include distributing cookies for the children who attend prayer. Ronald explains the effectiveness of this technique because it encourages the children to practice at a young age, and build a routine of it. He describes instances in which the children requested cookies after prayer when they were not offered as this has become a sense of familiarity to them. He also reinforces to his community that integration is a two-way street and that Canada requires flexibility in adapting to their newcomers as well. One of the religious websites lists the community groups available for newcomers to join. The leaders' biographies are also listed, which may offer further insight into the services that they can provide to their community.

It is important to note that these religious institutions have played a strong role in newcomers' lives as they are a source of social networking, which allows individuals to socialize with members of their community. This may have positive effects on reducing isolation and creating important links within the society which can assist in the resettlement process wholly.

5.2.4 The Case of the Iranian Therapist in Toronto

Amanda treats many Iranian women, who seek her help due to their shared cultures. She uses solution-focused therapy with her patients to focus on the present rather than the past and to make connections between the two time periods by analyzing similar reactions or reflections.

The therapy methods used by Amanda depend on the patient themselves and the issues they wish to address. According to Amanda, she uses community-based rehabilitation techniques for her Canadian-born patients. Conversely, for Iranian-born patients, she listens to them and notes patterns of behaviour, thoughts and feelings and works on the feelings that

arise from them as they often related to compounded issues of anxiety, depression and trauma. Amanda will also consult the patients' families and work with them in conjunction with her patient to resolve specific family-related issues.

The literature supports the therapist's observations describing these thoughts and behaviours. These studies demonstrate that newcomers undergo a cycle of culture shock after having arrived to Canada. Their initial reaction, lasting several months after arrival, is one of happiness and elation, and the ability to discuss their past experiences of war and take care of their basic needs (Cohon, 1981). The second phase of the process is when the individual recognizes the differences in their new surroundings and customs compared to their country of origin and reminisces about their past. The behaviours associated with this second phase include anxiety, depression, paranoia, somatic symptoms such as fatigue, weakness, physical pain and trouble sleeping and eating and can vary in severity (Cohon, 1981).

While Amanda's patients were mostly women, the cycle of culture shock is found in men as well who may also present the same feelings of anger, discomfort, frustration and confusion, as well as withdrawal and loneliness (GoC, 2014). Many of the coping strategies involve making an effort to adjust to the new country and to develop friendships while maintaining the relationships from their home country (GoC, 2014). These suggestions support the literature stating that social networks are an important component to adapting to any new country.

For example, she described a situation when an Afghani girl approached her whose parents had already decided that she would marry a 25-year old man as soon as she turned 18 years old. The girl felt conflicted because she did not want to get married and wanted to

study instead, but was afraid of disrespecting her parents. The counsellor offered to sit down with the girl's parents to discuss these concerns and to reassure them that it was acceptable to study in Canada. Amanda used herself as an example, stating that she studied in Canada and she was successfully able to build her career in Toronto, and still maintained certain aspects of her culture.

Amanda stated that her patients have preferred her services because she was born in Iran and has lived and studied in Canada. She felt her clients would see her as someone who has already 'crossed over', and who understand their lives without judgement. The fact that Amanda is a female therapist has notably been an important factor to seeking her care. Amanda provides examples of her patients seeking services from Iranian male therapists who have been judgemental and cause discomfort in the sessions. The patients further described to Amanda that these therapists as being in Canada physically, but mentally still in Iran, alluding to the fact that they maintain the Iranian culture and mentality, causing hesitation in the patients to be open in the sessions.

5.2.5 Newcomers' Expectations vs. Canadian Reality

Throughout the interviews with the counsellors, researchers and physicians related different examples as to how the newcomers had specific expectations about how government, markets and other institutions would function in Canada. A prominent and recurring example of false expectations is the perception of the role of the police force in society. They also told of how they tried to help newcomers adjust their expectations by offering guidance and allowing them to maintain their independence when establishing themselves in the new country.

5.2.6 Unwritten Code

The unwritten code, a term used by one of the counsellors, Sam, is a concept describing the struggle between two cultures that determine which values, beliefs and actions to adopt and live by. This struggle can become a cause of stress and anxiety to newcomers and even alienation from their community. These feelings are consistent with the literature that states that when the migrants identify the cultural differences in their new environment compared to their original customs, they will recall their past and this will cause mental symptoms such as anxiety and depression as well as psychosomatic symptoms like fatigue, weakness, insomnia and physical pain (Cohon, 1981). This is also supported by Amanda's observations in her work with Iranian women and described further below. Understanding the unwritten code is an integral component of the services provided to newcomers in Ottawa. As described by one of the organizations' websites, they provide services free of judgement, which demonstrates to their clients that this unwritten code will not be imposed in the sessions and that it an open, accommodating and safe space for the newcomers.

Sam describes this unwritten code specifically for when newcomers adopt certain traits from each culture and are free to act in any way they choose to because they feel that the community that will not report and judge their actions as being taboo or inappropriate by their culture's standards. As described by the counsellors, the Middle-Eastern cultures raise their children in a collective effort that involves the parents, grandparents, religious institutions and the community and instil the culture, values and customs in the children.

This form of collective upbringing ultimately becomes a factor in how much of an individual's culture is retained once they are relocated to another country. The retention is demonstrated by the relationships formed between families and their extended relatives as

well as other families who share the same background and customs. This cultural preservation is also marked by the decisions taken by the children, who maintain a sense of caution in their daily activities to preserve their family's reputation. As described by Mark and Sarah, this includes refraining from certain activities that would be deemed inappropriate, such avoiding mental health services to avoid having the family labeled or judged by the community.

The unwritten code will also affect the gender roles taken on by the members of the family. Women have reported difficulty when prioritizing their careers and education over the traditional role of getting married. The risks involved with this way of thinking include losing their families, as described by Amanda. While the overall values and customs shared are instrumental in creating and maintaining social networks to improve an individual's health, they may also incapacitate individuals to live their lives freely due to the constant reminder of the inner conflict faced between what they 'should' do and what they 'want' to do in life; a trend noticed by Amanda, Sid and Amal from both organizations.

In one example shared by Amanda, an Iranian mother did not want her five-year old daughter to ride her bicycle in the city because she was worried that, if the Iranian community saw her, it would impede her chances of getting married in the future because of the perception of losing her virginity to the bicycle. Although the mother felt very strongly about her decision not to allow her daughter to ride her bicycle, the child's father was very liberal and decided to take his daughter to a remote compound where she could ride without anyone seeing her. The mother would try to make the child feel guilty by telling her that she is risking the family's reputation in the community. These clashes in mentality occur within a family unit as well as within the community itself.

Men are also prone to this unwritten code, which affects their way of thinking with regards to the ego that accompanies the traditional male role in the culture. According to Nancy, an ego becomes prominent in older men, particularly those with higher education (e.g. Post-graduate degrees, doctors, engineers and other professional designations), which will affect the size of one's ego, and is imposed upon younger individuals and women. Nancy and almost all other counsellors have noted that this will affect the sessions, especially when discussing emotional or mental health or past experiences.

The counsellors have observed that men with lower levels of education are more open-minded about discussing their emotions and part experiences, whereas individuals with higher levels of education tend to avoid these topics of discussion and maintain a direct and formal demeanour. Nancy has also noted instances of being spoken down to by individuals with higher levels of education and this will shift the relationship between the counsellor and client to a formal encounter. The counsellor recalls an incident of an educated man (PhD) who was interested in receiving help with employment and who was direct with the counsellor regarding his goals and spoke down to her, as noted by his tone. In such situations, she did not attempt to create a bond or relationship with her client, but rather only provided him with the information requested.

Chapter 6: Structural Improvements and Policy Changes

6.1 Improvements to our Current System as Suggested by Interviewees

Working in the mental health system on a daily basis, the counsellors, researchers and physicians were able to provide valuable insight on the changes and improvements needed to be made to further develop the current system for migration and newcomers. This is an important priority in Canada and is recognized by Health Canada, Citizenship and

Immigration Canada and provincial organizations, to develop policy tools and programs to improve immigrant health (Gold and DesMeules, 2004).

6.2 Policy Changes

Different improvements were suggested by the interviewees, which include restoring medical insurance to newcomers and decreasing Canadian citizenship wait times. As described by Martin, a physician working on refugee health care, "When people arrive here, they really live in abject poverty, right? Like many people who end up on social assistance, the vast majority of people we see, and these initially end up on social assistance and that's a struggle".

Other improvements as suggested by Sam, include a greater coordination between the local, provincial and federal governments. This becomes important because the provincial governments are responsible for their health care systems, yet the issue is one of national proportions. It is important to understand the relationship between the immigration process and the social determinants of health to be able to provide the proper services and funding across Canada (Gold and DesMeules, 2004). This includes integrated services between Quebec and Ontario, which are key areas of migration, as well instilling a regulatory body to oversee the services offered to this population.

6.3 Perception Changes

As suggested by Amal, changes surrounding the perception of newcomers are integral to both the resettlement process for that population, as well as for Canadians and how the country welcomes them. Along with this integration, local improvements include outreach initiatives to have more people present for and ensuring that the patients are not all labeled as traumatized and diagnosed with PTSD, as suggested by Matt.

Amal also stressed the importance of educating clinical workers and the society on the perception of these individuals and shifting their image from being 'problems' and not to think of them as being 'problematic'. This perception also applies to the patients' background, and to channel them through the proper services that incorporate a cultural understanding to their care, as described by Sarah. These can include services that are offered by people from the same culture, as witnessed through Amanda – the therapist who serves the Iranian community. However, two other counsellors stressed the importance of having patients seek aid from other cultures and sources of knowledge and information to avoid being limited by their own. This is also reflected in the patients themselves, who may choose to avoid organizations and counsellors from their own culture due to past negative experiences had, which becomes the main impression of anything associated to that culture, as explained by the other counsellors. Nancy, a counsellor, described a situation in which a client had been mistreated and condemned by their country of origin's community for being part of a specific political group and therefore decided to avoid the organization completely because he expected the same treatment there and sought services elsewhere. Another client had expressed her feelings of avoidance of an organization due to having her private experiences divulged by one of the workers there.

Ester and Molly stress the significance of accurate referrals and state that providing the clients with the correct information and referrals for services in other organizations is necessary for the clients to make informed decisions and will help them navigate through the migration process. There are several instances in which the clients are misinformed (for example, the professional accreditation process) and will become discouraged and confused with regards to what steps need to be taken. Nancy supports this suggestion by noting the

importance of patients managing their expectations of the services provided, and the difference in services offered from one culture to another; especially prior to participating in the immigration process.

A frequent suggestion amongst all those interviewed was to increase funding to provide services to the immigrant population as well as to implement an evaluation system to determine the successes and failures of all the programs offered. This relates to the accountability of these programs, and Amanda described the difficulty encountered with the limited assistance offered by the government towards victims of domestic violence because it led to only a few of her patients being able to receive financial assistance.

According to Sarah, improvements need to be made to offer concentrated, collaborative and multi-disciplinary programs across Canada on a long-term basis and not continue in the present piecemeal approach. Sarah elaborates on this point, stating that a proper approach to identifying the settlement issues and adequate funding are required help this population and prevent them from leaving Canada to return to their countries of origin. In addition, establishing more front-line workers who speak various languages (e.g. Arabic, Farsi, Kurdish, among others) to be able to talk to newcomers without interpreters will benefit newcomers greatly.

Finally, suggestions were made to improve the hiring process in social service organisations for newcomers to include language proficiencies as one of the main assets to their candidacies – giving the clients a chance to utilize their knowledge of multiple languages in the workplace. According to Martin, the newcomers are "itching to work and get back into the workforce and contribute". There is an interesting paradox associated with this because the immigrant men who see their arrival in Canada as a temporary visit will

tolerate any type of employment, which is not the case for the men who immigrate to Canada permanently (Pedraza, 1991). Those who immigrate permanently tend to take greater risks in establishing themselves and home businesses, and to attain social mobility in their new home (Pedraza, 1991), which may also contribute to stress and difficulty in the resettlement process.

Chapter 7: Conclusions

The newcomers from conflict-affected countries come to Canada to begin a new life, but many of them are experiencing the adverse effects of having lived through war and experienced traumatic events. While these individuals are all affected differently by their past, many of these effects have taken the form of mental health disorders, and these disorders need to be assessed and treated. These mental health disorders are exacerbated by the stresses of resettling in a new society, culture, and country. It is Canada's duty as a host country to offer programs and services that will mitigate these effects and allow newcomers to establish themselves successfully.

My research examined the mental and social services that were offered to this population in the NCR, as well as the perception of the services offered by counsellors and health professionals as well as the newcomers themselves, as communicated to the front-line workers. It also determined what internal and external obstacles were present to them in the resettlement process.

Upon examining the programs and services provided by organizations in Ottawa, having interviewed their counsellors as well as researchers, physicians and community leaders in the area, it has become clear that the newcomer population has been offered

several services and resources to help in the resettlement process in Ottawa. While the city has implemented these programs and services, it is very evident that newcomers face many social and health obstacles and would benefit from certain policy changes and specifically tailored services that encompass their culture, beliefs and social networks.

This influence results in the fact that the culture does play a role in treatment options, but only in certain aspects of the treatment process. Despite the individualistic nature of the one-on-one sessions, such sessions have become a way to overcome the cultural taboos, stigma and shame that may occur during group sessions. Having said this, the mental health professionals all believe that it is important for their clients to have a community support system (including a supporting family network) if the therapy is to succeed. Culture and the mission of finding one's cultural identity is also a factor that undergoes many obstacles when moving to a new country. This also affects how individuals respond to the social services, norms and society's characteristics – which ultimately affect their resettlement. The obstacles related to language barriers, employment issues and stigma can also be addressed and overcome with specific counselling sessions, and the incorporation of social and religious networks as a means to create a circle of trust and familiarity for individuals that have strong attachments to their country of origin. This will also allow them to network with other members of the community and develop links that may assist them in the resettlement processes.

Counsellors, community leaders and therapists undergo different experiences with this population on a daily basis, but the consensus amongst them revolve around the fact that Canada must adjust its mental health services to this incoming population and offer services that are situation and culture-specific to build a stronger and healthier Canadian population.

The adjustments have already begun in certain areas of the city, however; it remains to be seen how much of a priority immigration resettlement services are for the NCR. It is a slow transition, but the changes that have occurred so far are indicative of the positive impact that they will have on a national scale.

Works Cited

Adler, Peter. (1977). Beyond Cultural Identity: Reflections on Multiculturalism. *Culture Learning*, East-West Center Press, 24-41

Arya, N. (2006). Deadly Addiction: India and Pakistan on the nuclear brink. *Medicine, Conflict and Survival, 22(*4), 261-274.

Awwad, A.M. (2001). Gossip, scandal, shame and honor killing: A case for social constructionism and hegemonic discourse. *Social Thought & Research, 24*(1/2), 39-52.

Beiser, M. (2005). The health of immigrants and refugees in Canada. *Revue Canadienne de Santé Publique, 68*(2), 30-44.

Berge, J.M., Mendenhall, T.J., Doherty, W.J. (2009). Using Community-Based Participatory Research (CBPR) to target health disparities in families. *Family Relations, 58*(4), 475-488.

Berg, B. (2009). *Qualitative Research Methods for the Social Sciences*. Boston: Pearson Education Inc.

Borjas, G.J. (1986). The Self-Employment Experience of Immigrants. *The Journal of Human Resources, (21)*4, 485-506.

Boyd, D. (2006). Resilience in newcomer families. *Canadian Issues*, 85-86.

Canadian Council for Refugees. (2012). Interim Federal Health Program. *Canadian Council for Refugees: Refugee Healthcare.* Web Aug 26, 2014.

Caplow, T. (1956). The dynamics of information interviewing. *The American Journal of Sociology*, *62*(2), 165-171.

Casey, T. and Dustmann, C. (2010). Immigrants' Identity, Economic Outcomes and the Transmission of Identity across Generations. *The Economic Journal, 120*(542), F31-F51.

CIC: Citizenship and Immigration Canada. (2015). Determine your Eligibility – Immigrate to Canada. Citizenship and Immigration Canada. Web 14 Jan. 2015 http://www.cic.gc.ca/english/immigrate/eligibility.asp

CIC: Citizenship and Immigration Canada. (2015). Six Selection Factors- Federal Skilled Workers. Citizenship and Immigration Canada. Web 12 Feb. 2015 http://www.cic.gc.ca/english/immigrate/skilled/apply-factors.asp

Cohon, D. (1981). Psychological adaptation and dysfunction among refugees. *International Migration Review, 15*(1/2), 255-275.

CRA : Canada Revenue Agency. (2015). Newcomers to Canada (Immigrants). Canada Revenue Agency. Web 13 Feb. 2015 http://www.cra-arc.gc.ca/newcomers/

Cutler, D.M., Glaeser, E.L., Vigdor, J.L. (2008). Is the Melting Pot Still Hot? Explaining the Resurgence of Immigrant Segregation. *The Review of Economics and Statistics, 90*(3), 478-497.

Drolet, M., Mohamoud, H. (2010). Dépasser une double invalidation : La lutte contre l'exclusion sociale de jeunes femmes immigrantes et de leur communauté. *Reflet, 16*(2), 90-117.

Eisenbruch, M. (1988). The mental health of refugee children and their cultural development. *International Migration Review, 22*(2), 282-300.

Ferrer, A. M., Picot, G. and Riddell, W. C. (2014), New Directions in Immigration Policy: Canada's Evolving Approach to the Selection of Economic Immigrants. *International Migration Review*, 48: 846–867. doi: 10.1111/imre.12121

Frankfort-Nachmias, C. & Nachmias, D. (2000). Research Methods in the Social Sciences (6th ed.). New York: Worth Publishers.

Gabriel, P.S., Morgan-Jonker, C., Phung, C.M.W., Barrios, R., Kaczorowski, J. (2011). Refugees and health care – the need for data: Understanding the health of government-assisted refugees in Canada through a prospective longitudinal cohort. *Canadian Journal of Public Health*, 102(4), 269-272.

Giacaman, R., Shannon, H.S., Saab, H., Arya, N., Boyce, W. (2006). Children of traumatized and exiled refugee families: Resilience and vulnerability. *European Journal of Public Health*, 17(4), 361-368.

Gold, J., DesMeules, M. (2004). National Symposium on Immigrant Health in Canada: an Overview. *Canadian Journal of Public Health, 95*(3), 13.

Government of Canada. (2014). Coping with culture shock. Government of Canada: Travel. Web 26 Aug. 2014. http://travel.gc.ca/travelling/living-abroad/culture-shock

Gray, P.S., Williamson, J.B., Karp, D.A., & Dalphin J.R. (2007). *The Research Imagination: An Introduction to Qualitative and Quantitative Methods.* Cambridge, England: Cambridge University Press.

Grazier, K.L. (2008). Integrating behavioral health care and primary care: Application of a clinical and economic model in culturally diverse communities. *International Journal of Public Administration*, 31(14), 1532-1547.

Guba, E.G., Lincoln, Y.S. (1994). *Competing paradigms in qualitative research. Handbook of qualitative research,* Thousand Oaks, CA: Sage.105-117.

Hayani, Ibrahim (2014). Arabs in Canada. *Global Research.* Web 15 Jan. 2015 http://www.globalresearch.ca/arabs-in-canada/5415869

Health Canada. (2010). Migration Health. Health Canada. Web. 25 Feb. 2015. http://www.hc-sc.gc.ca/sr-sr/pubs/hpr-rpms/bull/2010-health-sante-migr/index-eng.php

Horton, R. (2009). The occupied Palestinian territory: Peace, justice, and health. *The Lancet*, *373*(9666), 784-788.

Hosin, A.A. (2001). Children of traumatized and exiled refugee families: Resilience and vulnerability - A case study report. *Medicine, Conflict and Survival*, 17(2), 137-145.

Hosper, K., Nierkens, V., Nicolaou, M., Stronks, K. (2007). Behavioural Risk Factors in Two Generations of Non-Western Migrants: Do Trends Converge Towards the Host Population? *European Journal of Epidemiology*, *22*(3), 163-172.

Jack Jedwab (2013). Immigration and official language communities in Ottawa and Gatineau from the 2011 National Household Survey. Association for Canadian Studies. Web. 22 Sep. 2013 www.acs-aec.ca

Jones, L.B. (2007). Book reviews: "Community Music Therapy," Edited by Mercedes Pavlicevik and Gary Ansdell. *Music Therapy Perspectives*, *25*(1), 62.

Koch, S.C. (2009). Traumatised refugees: An integrated dance and verbal therapy approach. *The Arts in Psychotherapy*, *36*(5), 289-296.

LASSA. *Lebanese and Arab Social Services Agency (LASSA)*, 2013. Web. 22 Sep. 2013 http://www.lassa.ca

Li, G. (2007). Home Environment and Second-Language Acquisition: The Importance of Family Capital. *British Journal of Sociology of Education*, *28*(3), 285-299.

LSB. (2012) Life Story Board. *Vidaview Information Systems.* Web 22 Sep. 2014 http://vidaview.ca/

Ma, X. (2002). The First Ten Years in Canada: A Multi-Level Assessment of Behavioral and Emotional Problems of Immigrant Children. *Canadian Public Policy, 28*(3), 395-418.

Marshall, C. & Rossman, G.B. (1999). *Designing Qualitative Research.* Thousand Oaks, CA: Sage Publications.

Maximova, K. & Krahn, H. (2010). Health status of refugees settled in Alberta: Changes since arrival. *Canadian Journal of Public Health, 101*(4), 322-326.

McDonough, K. (1998). Can the liberal state support cultural identity schools? *American Journal of Education, 106*(4), 463-499.

McIntosh, A.J., Hinch, T., Ingram, T. (2002). Cultural Identity and Tourism. *International Journal of Arts Management. (4)*2, 39-49.

Medina, M.F. (2014). Disclosure of Difficult Life Events with a Visual Tool. *A Master's Thesis Submitted to the Faculty of Graduate Studies of the University of Manitoba, Winnipeg, MB. Department of Community Health Sciences*

Migration Policy Institute. (2003). Integration: The role of communities, institutions and the state. *Migration Information Source.* Web. 22 Sep. 2013 http://www.migrationpolicy.org/article/integration-role-communities-institutions-and-state/

OCISO. *Ottawa Community Immigrant Services Organization (OCISO),* 2013. Web. 22 Sep. 2013

OECD. (2009). *Organisation for Economic Co-operation and Development iLibrary: Migration.* Web. 22 Sep. 2013 http://www.oecd-ilibrary.org/sites/soc_glance-2008-en/04/03/index.html;jsessionid=v5cth8nj9avj.x-oecd-live-01?contentType=&itemId=%2Fcontent%2Fchapter%2Fsoc_glance-2008-7-en&mimeType=text%2Fhtml&containerItemId=%2Fcontent%2Fserial%2F19991290&accessItemIds=%2Fcontent%2Fbook%2Fsoc_glance-2008-en

OHIP. (2012).*OHIP Coverage Waiting Period.* Web. 13 Feb. 2015 http://www.health.gov.on.ca/en/public/publications/ohip/ohip_waiting_pd.aspx

Patton, M.Q. (2002). *Qualitative Research and Evaluation Methods*. Thousand Oaks, CA:Sage Publication Ltd.

Pedraza, S. (1991). Women and Migration : The Social Consequences of Gender. *Annual Review of Sociology, 17,* 305-325.

Punamaki, RL., Qouta, S., Miller, T., El-Sarraj, E. (2011). Who are the resilient children in conditions of military violence? Family- and child-related factors in a Palestinian community sample. *Peace and Conflict*, 17(4), 389-416.

Qin, D.B. (2006). "Our Child Doesn't Talk to Us Anymore": Alienation in Immigrant Chinese Families. *Anthropology and Education Quarterly, 37*(2), 162-179.

Ramon, S. (2009). Adult Mental Health in a Changing International Context : The Relevance to Social Work. *The British Journal of Social Work, 39*(8), 1615-1622.

Rochefort, D.A. & Portz, J.H. (1993). Different systems, shared challenges: Assessing Canadian mental health care from a U.S. perspective. *American Review of Canadian Studies, 23*(1), 65-82.

Ruwanpura, E., Mercer, S.W., Ager, A., Duveen, G. (2006). Cultural and spiritual constructions of mental distress and associated coping mechanisms of Tibetans in exile: Implications for Western interventions. *Journal of Refugee Studies, 19*(2), 187-202.

Sabatinelli, G., Pace-Shankin, S., Riccardo, F., Shahin, Y. (2009). Palestinian refugees outside the occupied Palestinian territory. *The Lancet, 373*(9669), 1063-1065.

Savin, D., Seymour, D.J., Littleford, L.N., Bettridge, J., Giese, A. (2005). Findings from mental health screening of newly arrived refugees in Colorado. *Public Health Reports (1974), 120*(3), 224-229.

Statistics Canada. (2013). Annual number of landed immigrants in Canada, 1852 to 2010. *Statistics Canada Census: 2011*. Web. 22 Sep. 2013 http://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-310-x/2011003/fig/fig3_1-2-eng.cfm

Taylor, S. & Bogdan, R. (1998). *Introduction to Qualitative Research Methods* (3rd ed.). New York: Wiley.

Ungar, M. (2011). Community resilience for youth and families: Facilitative physical and social capital in contexts of adversity. *Children and Youth Services Review, 33*(9), 1742-1748.

UN General Assembly. (1951). *Convention Relating to the Status of Refugees*. United Nations, Treaty Series. Geneva and New York.

van Tubergen, F. (2005). Self-Employment of Immigrants: A Cross-National Study of 17 Western Societies. *Social Forces, 84*(2), 709-732.

Walsh, F. (2002). A family resilience framework: Innovative practice applications. *Family Relations, 51*(2), 130.

Walsh, F. (2003). Family resilience: A framework for clinical practice. *Family Process, 42*(1), 1.

WHO. (2008). Glossary of Humanitarian Terms. *World Health Organization.* Web 22 Sep. 2013 http://www.who.int/hac/about/reliefweb-aug2008.pdf

Wilson, M. (2001). Black women and mental health: Working towards inclusive mental health services. *Feminist Review*, 68, 34-51.

Annexes

Annex A: Information Letter for Volunteer Consent

Lauchlan Munro
International Development & Global Studies

University of Ottawa

Jennifer Gedeon
International Development & Global Studies
University of Ottawa

Information Letter for Volunteer Consent

To whom it may concern,

My name is Jennifer Gedeon and I am currently studying a Masters in Globalization and International Development at the University of Ottawa. In order to successfully complete the program and obtain a degree, I must complete a research project and submit a thesis on a subject of my choice. Given my educational background and having a Bachelor of Health Sciences as well as a Bachelor of Social Sciences, Minor in Public Administration; my research will examine community-based rehabilitation as a model of mental health care for Middle-Eastern refugees in the National Capital Area. My research is being carried out under the supervision of Dr. Lauchlan Munro, from the School of International Development and Global Studies at the University of Ottawa.

The study aims to examine community-based rehabilitation treatment and determine the effects this technique has on refugees from the Middle East that have lived through the war. The study also aims to examine traditional psychiatric treatment methods on the same study population and to compare both.

Your participation in the study is strictly on a voluntary basis. If you accept to be involved, you will be invited to participate in a 60-75 minute interview. With your consent, the interviews will be audio-recorded for future transcription purposes. Once the recording of the interview is transcribed, it will be submitted to you in a password-protected document and encrypted email for your revision. The interview will take place in a location and at a time most convenient to you. You will, at all times during the interview, have the right to refuse answering to questions as well as having the right to modify or retract any information provided. You also reserve the right to withdraw from the study at any time as well as requesting that your answers provided are not used. There are no known risks associated to your participation in the study.

Your contribution to the study will help advance research associated to health care services used to treat mental health disorders in Middle Eastern refugees from war torn countries, a common study population.

The interview will be comprised of a series of open and semi-structured questions that will be provided to you beforehand. Any and all information shared throughout the interview will remain confidential and will be stored on an encrypted USB drive and kept in a locked cabinet in my supervisor's locked office and will only be accessed by my supervisor and I. The files will be kept for 5 years and destroyed in 2018 and will then be permanently erased and the transcriptions will be shredded.

The findings will be used towards the master's thesis submitted to the University of Ottawa and may also be presented at conferences and/or published in academic journals. Nevertheless, using pseudonyms and eliminating any identifiers will at all times respect the patients' confidentiality. The findings can be made available upon request.

The University of Ottawa Research Ethics Board has approved this research project and all questions regarding the ethical implications of the study can be addressed to:

[…]

If you are interested in participating in this study or would like to obtain more information, please contact my thesis supervisor and/or I using the contact information below.

Thank you and I look forward to your reply.

Jennifer Gedeon
International Development & Global Studies
University of Ottawa

Lauchlan Munro
International Development & Global Studies
University of Ottawa

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Annex B: Interview Consent Form

Title of the study: Examination of Community-Based Rehabilitation as a model of mental health care for Middle-Eastern refugees in the National Capital Area

** Note: There may be more than one researcher; the singular and the masculine gender have been used to simplify the text.*

Invitation to Participate: I am invited to participate in the abovementioned research study conducted by Jennifer Gedeon, a Master's student in Globalization and International Development at the University of Ottawa.

Purpose of the Study: The purpose of the study is to examine community-based rehabilitation treatment and determine the effects this technique has on refugees from the Middle East that have lived through the war. The study also aims to examine traditional psychiatric treatment methods on the same study population and to compare both.

Participation: My participation is strictly voluntary and will be comprised of 60-75 minute interviews consisting of a series of open and semi-structured questions that will be provided beforehand. The interview will take place at a time and location of my convenience and will be audio-recorded based on my consent. The transcripts will be made available for me to review and will be sent in a password-protected document via encrypted email.

Risks: I understand that there are no known risks associated with my participation in this study.

Benefits: My participation in this study will help advance research associated to health care services used to treat mental health disorders in Middle Eastern refugees from war torn countries, a common study population.

Confidentiality and anonymity: I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the contents will be used only for the purpose of completing and submitting a Master's thesis at the University of Ottawa and/or to be presented at conferences or published in academic journals. I understand that using pseudonyms and eliminating all identifiers in the data will protect my confidentiality.

Conservation of data: The data collected, including the transcripts and recordings will be kept in a secure manner on an encrypted USB stick and locked in the thesis supervisor's cabinet in his locked office. This data will only be accessed y the student researcher and the thesis supervisor and will be kept for five years then permanently destroyed, in 2018. The data on the USB key will be professionally deleted and then submitted to an electronics company for proper disposal and all transcripts and hard copies of data will be shredded.

Compensation: No compensation is offered for my participation to the research.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will not be used in the study upon my request.

The interviews will be audio-recorded with your consent for the purpose of future transcription. Please check off the appropriate box indicating whether or not you consent to having the interview audio-recorded.

☐Yes, I consent to having the interview for this study audio-recorded

☐No, I do not consent to having the interview for this study audio-recorded

Acceptance: I, _____, agree to participate in the above research study conducted by Jennifer Gedeon of the School of International Development and Global Studies at the University of Ottawa under the supervision of Dr. Lauchlan Munro.

If I have any questions about the study, I may contact the researcher or his supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5
Tel.: (613) 562-5387
Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: *(Signature)* Date: *(Date)*

Researcher's signature: *(Signature)* Date: *(Date)*

Annex C: Interview Guide

Interview Guide for Organization A Counselors

1) What position do you hold at Organisation A and how long have you had it?

2) What is your mandate and duties within Organisation A?

3) What is the purpose of the programs run at Organisation A for Middle Eastern refugees? What are its intended objectives?

4) Could you describe the history of when Organisation A began these groups and offering these services?

5) Could you describe the process of how these group therapies were developed?

6) What resources were made available to these group therapies and to the members participating in them?

7) Can you describe the demographic profile of the individuals attending these sessions? Age range, gender, approximate number of participants, background?

8) What techniques or therapy methods are used in the sessions?

9) How do you determine success in a session?

    a. With a specific technique?

10) What has the success rate been in the past concerning these programs?
    a. Why?

11) Which techniques used had a higher/better response from the participants?

12) Which techniques used had a lower response from the participants?

13) How do the participants' cultures play a role in the sessions?

14) How do you incorporate their cultures with the techniques used?

15) What are the goals of every group session and of the overall program?

16) What are the performance indicators used to determine a program's success?

17) Have you received specific feedback from participants regarding the methods used during the sessions?

18) In your opinion, what can be done to improve the methods used?

***

Interview Guide for Organization B Counselors

1) What position do you hold at Organisation B and how long have you had it?

2) What is your mandate and duties within Organisation B?

3) What is the purpose of the programs run at Organisation B for Middle Eastern refugees? What are its intended objectives?

4) Could you describe the history of when Organisation B began these groups and offering these services?

5) Could you describe the process of how these group therapies were developed?

6) What resources were made available to these group therapies and to the members participating in them?

7) Can you describe the demographic profile of the individuals attending these sessions? Age range, gender, approximate number of participants, background?

8) What techniques or therapy methods are used in the sessions?

9) How do you determine success in a session?
    a. With a specific technique?

10) What has the success rate been in the past concerning these programs?
    a. Why?

11) Which techniques used had a higher/better response from the participants?

12) Which techniques used had a lower response from the participants?

13) How do the participants' cultures play a role in the sessions?

14) How do you incorporate their cultures with the techniques used?

15) What are the goals of every group session and of the overall program?

16) What are the performance indicators used to determine a program's success?

17) Have you received specific feedback from participants regarding the methods used during the sessions?

18) In your opinion, what can be done to improve the methods used?

***

Questionnaire for Psychiatrists/Psychologists

1) How long have you been working as a psychiatrist/psychologist?

2) What is your mandate and duties?

3) What is the purpose of the programs run at the organization for Middle Eastern refugees? What are its intended objectives?

4) Could you describe the history of when the organization began these groups and offering these services?

5) Could you describe the process of how these group therapies were developed?

6) What resources were made available to these group therapies and to the members participating in them?

7) Can you describe the demographic profile of the individuals attending these sessions? Age range, gender, approximate number of participants, background?

8) What techniques or therapy methods are used in the sessions?

9) How do you determine success in a session?
    a. With a specific technique?

10) What has the success rate been in the past concerning these programs?
    a. Why?

11) Which techniques used had a higher/better response from the participants?

12) Which techniques used had a lower response from the participants?

13) How do the participants' cultures play a role in the sessions?

14) How do you incorporate their cultures with the techniques used?

15) What are the goals of every group session and of the overall program?

16) What are the performance indicators used to determine a program's success?

17) Have you received specific feedback from participants regarding the methods used during the sessions?

18) In your opinion, what can be done to improve the methods used?